

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

PRINTED: 05/08/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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
E 0000 Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62.</p> <p>Survey Dates: April 3rd, 4th, 5th, & 6th of 2023</p> <p>Facility ID: 005156</p> <p>Census: 25 in-center hemodialysis 8 home peritoneal dialysis</p> <p>At this Emergency Preparedness survey, Lawrenceburg Dialysis, was found out of compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62.</p> <p>QR Completed on 4/13/2023 A4</p>	E 0000		
E 0028 Bldg. 00	<p>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:]</p> <p>(9) A process by which the staff can confirm</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
shelly Fette	Facility Administrator	05/08/2023

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: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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>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.</p> <p>Based on record review, interview, and observation, the facility failed to ensure that the emergency cart (crash cart) was easily accessible and maintained in a ready-to-use condition in 1 of 1 facilities reviewed.</p> <p>Findings Include:</p> <p>A policy titled, "Physical Environment," revised April 2018, was provided by the Manager of Clinical Services on 04/06/2023 at 11:46 AM. The policy indicated but was not limited to, "4. The dialysis facility will implement and maintain a program to verify that all equipment, including emergency equipment" ... "are maintained and operated in accordance with the manufacture's recommendations."</p> <p>A policy titled, "Emergency Equipment Checks," revised April 2022, was provided by the Manager of Clinical Services on 04/05/2023 at 3:47 PM. The policy indicated but was not limited to, "PURPOSE: To verify that emergency equipment is maintained in a ready-to-use condition." ... "Weekly" ... "Emergency cart (crash cart) is clean, operational and supplies/medications have not expired."</p> <p>A policy titled, "Infection Control for Dialysis Facilities," revised April 2023 was provided by the Manager of Clinical Services on 04/05/2023 at 3:47 PM. The policy indicated but was not limited to, "Supplies will be stored in a manner that maintains their integrity" ... "Supplies will not be open until</p>	E 0028	<p>The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 04/07/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 1-05-01 "Infection Control for Dialysis Facilities" and Policy 1-02-08 "Emergency Equipment Checks" with emphasis on but not limited to: 1. Infection Control: 1) Supplies will be stored in a manner that maintains their integrity. Expiration date and package integrity will be verified prior to use; Supplies will not be opened until time of use; Anytime the integrity of a package with or without an expiration date is in question, i.e., torn, ripped, wet or contaminated, the package and its contents must be disposed of and not used. 2. Emergency Equipment Checks: 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.</p>	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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 0000 Bldg. 00	<p>time of use." ... "Anytime the integrity of a package with or without an expiration date is in question, i.e. torn, ripped, wet or contaminated, the package and its contents must be disposed of and not used."</p> <p>During an observation on the treatment floor on 04/05/2023 at 11:54 AM, the emergency cart was found to have an opened oxygen mask and a yankauer (suction tubing used to clear an airway and prevent aspiration during an emergency event) that had been opened and connected to the suction machine. The end of the yankauer used to suction the patient's airway was placed inside the opened sterile package.</p> <p>During an interview on 04/05/2023 at 11:58 AM the charge nurse agreed that the opened oxygen mask and Yankauer found to be connected to suction was no longer considered clean/sterile and should not be used.</p> <p>During an interview on 04/05/2023 at 12:00 PM the Manager of Clinical Services agreed that the opened oxygen mask and Yankauer found to be connected to suction was no longer considered clean/sterile and should not be used. Indicated that the emergency cart had been checked on Monday and the Yankauer was not opened and connected at that time.</p> <p>This visit was for a federal ESRD recertification</p>	V 0000	<p>Verification of attendance is evidenced by teammate's signature on the in-service sheet. On 04/05/23, the Facility Administrator immediately discarded opened oxygen mask and yankauer package, then replaced them with sealed mask and yankauer package. The Facility Administrator or designee will perform audits to verify crash cart is being checked as clean, operational, and supplies are not opened or expired: daily for two (2) weeks, and weekly for two (2) weeks, then monthly for two (2) months. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the audit results with teammates during homeroom meetings and with the Medical Director during 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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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 0147 Bldg. 00	<p>and complaint survey.</p> <p>Complaint IN00404246 - Federal deficiencies related to the allegations were cited.</p> <p>Survey Dates: April 3rd, 4th, 5th, & 6th of 2023</p> <p>Facility ID: 005156</p> <p>Census: 25 in-center hemodialysis 8 home peritoneal dialysis</p> <p>494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children</p> <p>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.</p> <p>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.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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>VI. Catheter and catheter-site care</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>Based on record review, interview and observation, the facility failed to ensure that staff were following CVC (Central Venous Catheter-access used to complete hemodialysis) policy to reduce the risk of infection in 1 of 2 CVC initiations observed.</p> <p>Findings Include:</p> <p>A policy titled, "Central Venous Catheter (CVC) with ClearGuard HD Antimicrobial End Caps Procedure," revised April 2023 was provided by the MCS (Manager of Clinical Services) on 04/06/2023 at 11:46 AM. The policy indicated but was not limited to, "16. Using aseptic technique, remove each cap. One at a time, disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub 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." ... "17. Attach sterile 10 ml syringes to the arterial and venous limbs."</p> <p>A policy titled, "Infection Control for Dialysis Facilities," revised April 2023 was provided by the MCS on 04/05/2023 at 3:47 PM. The policy indicated but was not limited to, "Hand Hygiene" ... "All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene" ... "d. after patient and dialysis delivery system contact."</p> <p>During an observation on 04/03/2023 at 10:45 AM,</p>	V 0147	<p>The Facility Administrator or designee held mandatory in-service for all Clinical Teammates starting on 04/10/23. Surveyor observations were reviewed. Education included but was not limited to a review of Procedure 1-04-02B "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure" and Policy 1-05-01 "Infection Control for Dialysis Facilities" with emphasis on but not limited to: 1. CVC care: 1) Step #16: Using aseptic technique, remove each cap. One at a time, disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub 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. 2) Step #17: Attach sterile 10ml syringes to the arterial and venous limbs. 2. Infection control: 1) All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene: d. after patient and dialysis delivery system contact... Verification of attendance at in-service will be evidenced by</p>	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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 0250 Bldg. 00	<p>PCT 3 was observed initiating dialysis with a CVC for Patient #2. After exit site care, PCT 3 was observed disinfecting the hubs of the CVC limbs with an alcohol prep pad prior to connecting the 10 milliliter syringes to the venous and arterial limbs when the hemodialysis began alarming. PCT 3 then stopped disinfecting the CVC limbs to silence the hemodialysis machine, pushing the mute button with clean gloved hand, then returned to Patient #2 and continued disinfecting the CVC limbs. No glove change or hand hygiene was observed. PCT 3 was observed doing this action twice with the absence of completing hand hygiene and/or glove change.</p> <p>494.40(a) DIALYS PROPOR-T-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method</p>		<p>teammates signature on in-service sheet.</p> <p>The Facility Administrator or designee will conduct observational audits to verify infection control practices and CVC care are performed per policy: daily for two (2) weeks with at least one observation for each teammate performing CVC care, then weekly for two (2) weeks. Ongoing compliance will be monitored with monthly infection control audit. Instances of non-compliance will be addressed immediately.</p> <p>The Facility Administrator or designee will review the audit results with teammates during homeroom meetings and with the Medical Director during 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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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 starting the treatment of the next patient.</p> <p>Based on record review, interview and observation, the facility failed to ensure proper use of the Phoenix Meter (independent meter used to verify pH testing of the dialysate) in 1 of 2 observations.</p> <p>Findings Include:</p> <p>A policy titled, "Measuring Conductivity, Temperature, and/or pH Using the Phoenix XL Conductivity Meter," dated April 2022 was provided by the Manager of Clinical Services on 04/05/2023 at 2:45 PM. The policy indicated but was not limited to, "8. Rinse the cell and syringe interior by drawing dialysis quality water through the cell filling the syringe. Expel and discard water. The phoenix meter should be rinsed free of dialysate between uses."</p> <p>During an observation on 04/05/2023 at 12:10 PM, PCT 1 was observed checking the pH at Station 2, Patient #2. After checking the pH with the independent Phoenix meter directly from the hemodialysis machine, PCT 1 was observed wiping down the phoenix meter with a bleach solution and returning it to the cradle for next use. PCT 1 failed to rinse the phoenix meter with quality water.</p> <p>During an interview with PCT 1 on 04/05/2023 at 12:12 PM, PCT 1 agreed that the phoenix meter should have been rinsed after use.</p>	V 0250	<p>The Facility Administrator or designee held mandatory in-service for all Clinical Teammates starting on 04/10/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 2-08-01G Measuring Conductivity, Temperature, and/or pH Using the Phoenix Conductivity Meter" with emphasis on but not limited to: 1) When you are finished with the Phoenix meter, RINSE interior thoroughly with dialysis quality water. Disinfect the exterior of the meter with 1:100 bleach solution before taking to a common clean area or used in another station.</p> <p>Verification of attendance will be evidenced by teammate signature on in-service sheet. All clinical teammates will complete the Phoenix Meter Skills Checklist immediately.</p> <p>The Facility Administrator or designee will perform observational audits of Phoenix meter use to verify that rinsing is completed in-between each use: daily for two (2) weeks, then weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly facility internal biomedical audits. Instances of non-compliance will be addressed immediately.</p> <p>The Facility Administrator or designee will review the audit</p>	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 0455 Bldg. 00	<p>494.70(a)(4) PR-PRIVACY & CONFIDENTIALITY-RECORDS The patient has the right to-</p> <p>(4) Privacy and confidentiality in personal medical records; Based on observation and interview the facility failed to ensure that the patient's name and health information was protected in 1 of 1 facilities reviewed.</p> <p>Findings Include:</p> <p>A policy titled, "Patient Rights and Patient's Standards of Conduct, Responsibilities, and Facility Rules," revised October 2021 was provided by the Manager of Clinical Services on 04/06/2023 at 11:46 PM. The policy indicated but was not limited to, "27. To know my medical records and the information contained will be considered private and confidential and only released in compliance with state and federal law."</p> <p>During an observation on 04/03/2023 at 11:10 AM a post-it note with Patient # 7 full name and Heparin dose (medication used during dialysis to prevent clotting of blood) was found attached to</p>	V 0455	<p>results with teammates during homeroom meetings and with the Medical Director during 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.</p> <p>The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 04/14/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 3-01-07A "Patient's Rights" with emphasis on but not limited to: 1) YOUR RIGHTS AS A PATIENT: To know my medical records and the information contained will be considered private and confidential and only released in compliance with state and federal law. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. Upon hearing surveyor's</p>	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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 0715 Bldg. 00	<p>the computer at the nurse's station in full view of other patients.</p> <p>During an interview on 04/03/2023 at 11:59 AM, the Manager of Clinical Services and GFA (Group Facility Administrator) agreed that patient information should be maintained in such a way to protect the patient.</p> <p>494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must-</p> <p>(2) Ensure that-</p> <p>(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers;</p> <p>Based on record review, observation and interview, the medical director failed to ensure the</p>	V 0715	<p>observations, the Facility Administrator or designee removed all post-it notes with patient health information (PHI) from the charge nurse's computer. The Facility Administrator or designee will conduct observational audits to verify the patient's right to privacy and confidentiality of medical records is protected: daily for two (2) weeks and weekly for two (2) weeks, then monthly for two (2) months. Instances of non-compliance will be addressed immediately. The Facility Administrator will review audit results with the Medical Director monthly during Quality Assessment and Performance Improvement meetings known as Facility Health Meetings, with supporting documentation in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction</p> <p>A Governing Body meeting with the Medical Director, Facility Administrator, Director of Nursing</p>	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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>facility followed their own policies and procedures regarding clean supplies stored in an area to prevent contamination prior to use and medications were secured in 1 of 1 facilities observed.</p> <p>Findings Include:</p> <p>A policy titled, "Physical Environment," revised April 2018 was provided by the Manager of Clinical Services on 04/06/2023 at 11:46 PM. The policy indicated but was not limited to, "Supplies are stored as to minimize deterioration, contamination, or breakage." "Where there is potential for water damage or bacterial growth."</p> <p>A policy titled, "Medication Policy," revised October 2022 was provided by the Manger of Clinical Services on 04/06/2023. The policy indicated but was not limited to, "Non-refrigerated medications are to be stored in cabinet (s) and locked at close of each business day or if not under the supervision by the licensed teammate or per state regulations."</p> <p>During an observation on 04/03/2023 at 11:27 AM, 2 boxes of supplies, BD Blood Collection Assembly with Male Leur Locks, used to obtain blood samples were stored under the laboratory sink, with the potential for water damage to occur on the clean supplies.</p> <p>During an observation on 04/05/2023 at 10:49 AM, RN (registered nurse) 4 was observed drawing up Heparin (a medication used to prevent clotting of blood in hemodialysis) in syringes for the next shift of patients. RN 4 then placed each Heparin filled syringe on top of the correlating supply packets prepared in advanced for the next shift of patients that was stored on the nurse's station</p>		<p>and Regional Operations Director was held on 04/19/23 to review the results of the survey ending on 04/06/23. The Governing Body reviewed Policy COMP-DD-017 "Medical Director Qualifications and Responsibilities" with the Medical Director, who acknowledges that he/she is responsible to ensure the facility teammates are trained and follow policy and procedure relative to patient admissions, patient care, infection control, and safety. Plans of correction have been developed and initiated to correct identified deficiencies and to sustain compliance.</p> <p>The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 04/14/23. Surveyor observations were reviewed. Education included but was not limited to a review of facility policies with areas of emphasis on but not limited to: 1. Policy 8-01-04 Physical Environment": 1) Supplies are stored as to minimize deterioration, contamination or breakage. The Facility Administrator or designee will audit supplies to verify proper storage locations, [including none under sinks]: daily for two (2) weeks, weekly for two (2) weeks and ongoing with Monthly OSHA and Safety Checklist. Instances</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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>counter located in the middle of the treatment room.</p> <p>During an interview on 04/03/2023 at 11:59 AM with the GFA (Group Facility Administrator) and the Manager of Clinical Services, both agreed that supplies should not be stored under the sink due to risk of water damage.</p> <p>During an interview with RN 4 on 04/05/2023 at 10:49 AM, RN 4 indicated that this was a normal practice to leave the medication out on the counter unsupervised. Agreed that patients would have access to the medication.</p>		<p>of non-compliance will be addressed immediately.</p> <p>2. Policy 1-06-01 "Medication Policy": 1) Non-refrigerated medications are to be stored in cabinet(s) and locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations. The Facility Administrator or designee will audit to verify medications are secured at the end of the business day, and if not under supervision of a licensed teammate: daily for two (2) weeks, weekly for two (2) week, and monthly for two (2) months. Ongoing compliance will be monitored with monthly medication inventory. Instances of non-compliance will be addressed immediately.</p> <p>Verification of attendance at all in-services will be evidenced by teammates' signatures on the in-services sheets.</p> <p>The Medical Director will review progress of teammate education, results of all audits, and adherence to this plan of correction during monthly Quality Assessment Performance Improvement meetings known as the Facility Health Meeting. The Facility Administrator will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes. Action plans will be evaluated for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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>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.</p> <p>(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:</p> <p>(i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (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</p>		effectiveness, new plans developed as applicable to achieve compliance with teammate adherence to policy and procedure. The Facility Administrator on behalf of the Governing Body is responsible for compliance with this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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>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> <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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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>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 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 721 RUDOLPH WAY GREENDALE, IN 47025
--	---

(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>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 (x) Contingency plans for staff who are not fully vaccinated for COVID-19.</p> <p>Effective 60 Days After Publication: (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; Based on record review and interview, the facility failed to ensure adequate additional precautions to be implemented to mitigate the spread of COVID-19 (infectious respiratory disease) for unvaccinated staff that provided direct patient care in the treatment area that went above standard precautions currently in place for 1 of 1 Facility reviewed.</p> <p>Findings include:</p> <p>A March 2022 policy titled "Covid-19 Vaccination Policy for Dialysis Facilities and Programs" was provided by the manager of clinical services on 04/03/2023 at 4:00 PM. 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,</p>	V 0800	The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 04/07/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 4-06-08 "COVID-19 Vaccination Policy for Dialysis Facilities and Programs" with emphasis on but not limited to: 1) Contingency plan for 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	05/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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>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>During an interview on 04/03/2023 at 4:00 PM, the MCS (manager of clinical services) agreed that all staff are following CDC recommendations, however, the policy states that unvaccinated staff additional precautions include only social distancing in the break room and allowing staff to briefly remove mask to eat/drink.</p>		<p>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 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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
			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 CDC-recommended precautions for unvaccinated teammates. Because DaVita has unvaccinated teammates in the facility, all people (including 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 drinking. The additional precautions for the breakroom include social distancing, staggering breaks to minimize the number of 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 unvaccinated teammates)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCEBURG DIALYSIS CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 721 RUDOLPH WAY GREENDALE, IN 47025
--	--

(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
			throughout its facilities in order to mitigate the spread of COVID-19. Verification of attendance is evidenced by teammate's signature on the in-service sheet. The Facility Administrator or designee will conduct a COVID-19 Field Audit Tool weekly for four (4) weeks to verify that all teammates including unvaccinated teammates are following the policy. Results of audits will be reviewed with 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 ongoing compliance with this plan of correction.	