STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152581	A. BUILDING 00 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MERRILLVILLE DIALYSIS	9223 TAFT MERRILLVILLE, IN 46410

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62 Survey Dates: 04/21/2025 to 04/25/2025 CCN: 152581 Active Census: In-center Hemodialysis Patients: 59 Peritoneal Dialysis Patients: 14 At this Emergency Preparedness Survey, Merrillville Dialysis, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62.	E 0000		
V 0000 Bldg. 00	This visit was for a CORE federal recertification of an ESRD Provider. Survey Dates: April 21, 22, 23, 24, and 25, 2025 CCN: 152581 Census by Service Type: In-Center Hemodialysis: 59 Home Peritoneal Dialysis: 14 Total Census: 73	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sheli Stout	Facility Administrator	05/15/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	No Isolation Room, Area, Nor Waiver, Built Before 02/09/2009 Requested addition of service: Peritoneal Dialysis Training and Support in a Skilled Nursing Facility The abbreviations used in this report: RN for registered nurse and PCT for patient care technician. QR: A 1 5/02/2025			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the dialysis facility failed to ensure staff removed gloves, performed hand hygiene (hand sanitizing with an alcohol-based antiseptic or hand washing) between patients and stations, after glove removal, and during central venous catheter care [CVC] (large catheter into vein) in 4 of 7 observations of PCT 3 (with Patient #16, Patient #22, Patient #24, and in Station #13), in 2 of 3 observations of PCT 1 (with Patient #6 and Patient #24) and in 2 of 5 observations of CVC access care of intiation and discontinuation (PCT 3). Findings include: 1. A revised policy, dated April 2023, titled, "Infection Control For Dialysis Facilities," indicated staff would perform hand hygiene upon entering and exiting the patient treatment area, prior to gloving and immediately after glove removal, after patient and dialysis delivery system	V 0113	The Facility Administrator will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 4/28/2025. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) HAND HYGEINE - All teammates…will perform hand hygiene: upon entering and exiting the patient treatment area, prior to gloving and immediately after removal of gloves…after patient and dialysis delivery system contact…between patients…before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. The Facility	05/24/2025

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	contact, between patients, before touching clean areas and during station cleaning for 2. During an observation, on 04/21/2025, beginning at 10:15 AM, PCT 3 was at Station #15, with Patient #22, PCT 3 had gloves on, touched Patient #22's hemodialysis [HD](a process to filter the blood of a patients whose kidneys do not work normally) machine, exited Station #15, without performing hand hygiene or glove change entered Station #14, with Patient #9, and touched Patient #9's HD machine. During an observation, on 04/21/2025, beginning at 10:15 AM, PCT 3 was at Station #13, with Patient #23, PCT 3 had gloves on and touched Patient #23's HD machine, exited Station #13, without performing hand hygiene or glove change entered Station #12, with Patient #8, and PCT 3 touched Patient #8's PCT machine. During an observation, on 04/21/2025, beginning at 10:45 AM, PCT 3 was cleaning Station #14, removed her gloves, without performing hand hygiene applied new gloves and emptied the drain bucket. During an observation, on 04/22/2025, beginning at 11:00 AM, PCT 3 was at Station #7, with Patient #16, for CVC initiation. During the observation, PCT 3 removed the dressing to the CVC site, removed her gloves and without performing hand hygiene applied new gloves and touched the HD machine, PCT 3 then exited Station #7, entered Station #5 and removed gloves. During an observation, on 04/22/2025, beginning at 2:05 PM, PCT 3 discontinued the CVC, for Patient #16, at Station #7. During the observation, PCT 3 discontinued 1 line, removed gloves and		Administrator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	without performing hand hygiene applied new gloves and flushed the 2nd line. During the observation, PCT 3 used a glove that was not applied to her hand to touch the HD machine. During an observation, on 04/22/2025, beginning at 2:05 PM, PCT 3 was wearing gloves, removed the blood lines for the Station #7's HD machine, placed the lines in the biohazard bag and without performing hand hygiene or changing gloves entered Station #10 with Patient #19, touched the HD machine, then PCT 3 removed her gloves and without performing hand hygiene applied new gloves. 3. During an observation, on 04/21/2025, beginning at 10:30 AM, PCT 1 was at Station #10, with Patient #24, PCT 1 had gloves on, touched Patient #24's HD machine, exited Station #10, PCT 1 removed her gloves and without performing hand hygiene, went to the center supply station, PCT 1 returned to Station #10 applied new gloves and typed on the computer, PCT 1 removed her gloves and without performing hand hygiene applied new gloves and entered Station #14. During an observation, on 04/21/2025, beginning at 11:05 AM, PCT 1 was at Station #14, with Patient #6, PCT 1 had gloves on and removed her gloves, without performing hand hygiene she applied new gloves and adjusted the arteriovenous fistula (access for HD) needles. 4. During an interview, on 04/21/2025, beginning at 11:40 AM, PCT 3 indicated gloves should be changed and hand hygiene should be done before and after patient care and between patients' stations.			

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V 0116 Bldg. 00	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Based on observation, record review, and interview, the dialysis facility failed to ensure non-disposable items taken into the dialysis station were disinfected before being taken to a common clean area or used on another patient in 1 of 2 observations of a station set up (PCT 4). Findings include: 1. A revised policy, dated April 2023, titled, "Infection Control For Dialysis Facilities," indicated non-disposable items were to be disinfected after each patient use, and prior to removal from treatment station. 2. During an observation, on 04/22/2025, beginning at 11:15 AM, PCT 4 brought the phoenix meter to Station #6 with Patient #15, they touched the hemodialysis machine to obtain a water sample; PCT 4 returned the phoenix meter to the clean sink counter and failed to clean the phoenix meter. 3. During an interview, on 04/22/2025, beginning at 2:20 PM, PCT 3 indicated the phoenix meter should be cleaned after each use at a hemodialysis station.	V 0116	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 4/28/2025. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) DISINFECTION - Non-disposable items are to be disinfected after each patient use, prior to removal from treatment area/station…The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for	05/24/2025

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			effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0126 Bldg. 00	494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Based on record review, and interview, the dialysis facility failed to ensure Hepatitis B (liver infection) vaccination surveillance and monitoring and failed to ensure susceptible (with a Hepatitis B antibody less than 10) patients were offered a Hepatitis B vaccination in 40% of in center hemodialysis [HD] (a process to filter the blood of a patients whose kidneys do not work normally) patients without a documented refusal (Patient #1, Patient #15, Patient #17, Patient #22, Patient #24, Patient #25, Patient #27, Patient #28, Patient #29, Patient #30, Patient #31, Patient #32, Patient #33, Patient #34, Patient #35, Patient #36, Patient #37, Patient #38, Patient #39, Patient #40, Patient #41, and Patient #42). Findings include: 1. A revised policy, dated April 2024, titled, "Hepatitis B Surveillance, Vaccination, Infection Control Measures and Isolation Guidance," indicated all permanent patients would have a Hepatitis B surface antigen and Hepatitis B surface antibody upon admission and if the Hepatitis B antibody was less than 10 and the Hepatitis B antigen was negative the patient would be offered a vaccination series. The policy	V 0126	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-05-02 “Hepatitis B Surveillance, Vaccination, Infection Control Measures and Isolation Guidance” starting on 4/28/2025. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) All permanent patients including AKI patients will have HBV serologic testing drawn immediately upon admission to the facility and results known within seven (7) days of admission (i.e., Hepatitis B Surface antigen [HBsAg], Total Hepatitis B Core Antibody [total anti-HBc or HBcAb], and Hepatitis B Surface Antibody [anti-HBs or HBsAb]). 2) ADMISSION SCREENING utilizing facility baseline/admit results – Antigen: Negative; Antibody: <10 - Offer	05/24/2025

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	indicated an annual Hepatitis B antibody would be obtained. The policy indicated if a Hepatitis B surface antibody was less than 10 after a full vaccine series the patient would be revaccinated with an additional full series, and no additional doses of vaccine were warranted for patients who do not respond to a full second series. The policy indicated if the Hepatitis B surface antibody was greater than 10 consider the patient immune and retest annually and if the Hepatitis B surface antibody was less than 10 on an immune patient due to vaccination a booster dose of the Hepatitis B vaccine would be administered with a physician order. 2. A Vaccinations and Surveillance Report, for Patient #25, indicated a Hepatitis B surface antibody, dated 03/15/2024 of 8 and a Hepatitis B surface antibody, dated 03/03/2025 of 6. The Report indicated a Hepatitis B vaccine was given 01/13/2020, 02/17/2020, 03/20/2020, and 07/17/2020. The Report failed to evidence Patient was offered, received, or refused a repeat the Hepatitis B vaccine/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #25 should have been offered a Hepatitis B vaccine booster. 3. A Vaccinations and Surveillance Report, for Patient #1, indicated a Hepatitis B surface antibody, dated 04/03/2024, of less than 3 and a Hepatitis B surface antibody, dated 02/20/2025 of less than 3. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccine/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #1 should have been and was not offered a Hepatitis B		vaccination series… Annual booster if annual antibody drops below 10…3) Test all vaccinated patients for HBsAb one (1) to two (2) months after the last dose of the full vaccine series…4) If hepatitis B surface antibody (HBsAb) is less than (<) 10 mIU/mL, consider the patient susceptible, revaccinate with an additional full series, and retest for HBsAb one (1) to two (2) months after the last dose of the second series. 5) No additional doses of vaccine are warranted for those patients who do not respond to a full second series. 6) If the hepatitis B surface antibody (HBsAb) is greater than or equal to (>) 10 mIU/mL, consider patient immune, and retest annually for HBsAb. 7) On annual retesting of immune patients due to vaccination, HBsAb less than (<) 10 mIU/mL, 10 mIU/mL, with nephrologist order, administer a booster dose of vaccine. The Facility Administrator, Clinical Coordinator, or Registered Nurse will audit one hundred percent (100%) of patients' hepatitis status and follow-up, if indicated, in accordance with facility policy. The Facility Administrator, Clinical Coordinator, or Registered Nurse will audit one hundred percent (100%) of hepatitis status for newly admitted patients monthly x 6 months to verify compliance with facility policy.	

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	vaccination series. 4. A Vaccination and Surveillance Report, for Patient #27, indicated a Hepatitis B surface antibody, dated 02/20/2025, of 8. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccine/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #27 needed to be offered a Hepatitis B booster vaccine. 5. A Vaccination and Surveillance Report, for Patient #28, indicated a Hepatitis B surface antibody, dated 10/31/2023 of 3, a Hepatitis B surface antibody, dated 04/18/2024, of less than 3, and a Hepatitis B surface antibody, dated 02/21/2025 of 3. The Report indicated one Hepatitis B vaccine was given 04/12/2022. The Report failed to evidence Patient was offered, received, or refused a repeat Hepatitis B vaccine/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #28 should have been offered a Hepatitis B booster vaccine. 6. A Vaccination and Surveillance Report, for Patient #29, indicated a Hepatitis B surface antibody, dated 11/09/2023 of less than 3, a Hepatitis B surface antibody, dated 04/17/2024, of less than 3, and a Hepatitis B surface antibody dated 02/26/2025 of less than 4. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccine/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #29 should have been offered a Hepatitis B booster.		Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	7. A Vaccination and Surveillance Report, for Patient #30, indicated a Hepatitis B surface antibody, dated 02/26/2025, of 9. The Report indicated Patient received Hepatitis B vaccinations 04/07/2023, 05/10/2023, 07/26/2023 and 04/12/2024. The Report failed to evidence Patient was offered, received, or refused a repeat Hepatitis B vaccine/booster after the 02/26/2025 Hepatitis B surface antibody result. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #30 would need to be offered a Hepatitis B booster vaccine. 8. A Vaccination and Surveillance Report, for Patient #31, indicated a Hepatitis B surface antibody, dated 11/02/2023 of less than 3, a Hepatitis B surface antibody, dated 04/18/2024 of less than 3, and a Hepatitis B surface antibody, dated 02/20/2025, less than 3. The Report indicated Hepatitis B vaccinations were given 07/10/2023, 08/21/2023, and 09/18/2023. The Report failed to evidence a repeat Hepatitis B vaccine/booster was offered, refused, or received. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #31 needed to be offered a Hepatitis B vaccination series. 9. A Vaccination and Surveillance Report, for Patient #17, indicated a Hepatitis B surface antibody, dated 02/27/2025, of 3. The Report failed to evidence a Hepatitis B vaccine/booster was offered, refused, or received. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #17 needed to be offered a Hepatitis B vaccination booster. 10. A Vaccination and Surveillance Report, for			

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	Patient #24, indicated a Hepatitis B surface antibody, dated 08/08/2022, of less than 3, a Hepatitis B surface antibody, dated 10/30/2023, of less than 3, and a Hepatitis B surface antibody, dated 02/21/2025, of less than 3. The Report indicated Patient received Hepatitis B vaccines on 11/22/2022, 12/26/2022, 01/23/2023, and 07/17/2023. The Report failed to evidence a repeat Hepatitis B vaccine/booster was offered, refused, or received. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #24 needed to be offered a Hepatitis B vaccination series. 11. A Vaccination and Surveillance Report, for Patient #15, indicated a Hepatitis B surface antibody, dated 09/05/2024, of less than 3 and a Hepatitis B surface antibody, dated 02/21/2025, of less than 3. The Report failed to evidence a Hepatitis B vaccine/booster was offered, refused or received. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #15 needed to be offered a Hepatitis B vaccination series. 12. A Vaccination and Surveillance Report, for Patient #22, indicated a Hepatitis B surface antibody, dated 10/22/2024, of less than 3, a Hepatitis B surface antibody, dated 05/09/2024 of less than 3, and a Hepatitis B surface antibody, dated 02/21/2025, of 4. The Report indicated Patient received a Hepatitis B vaccination on 08/10/2024 and 09/10/2024. The Report failed to evidence the Hepatitis B series was completed. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #22 missed the 3rd dose of the Hepatitis B vaccine and the Hepatitis B vaccination series needed to be			

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	restarted. 13. A Vaccination and Surveillance Report, for Patient #32, indicated a Hepatitis B surface antibody, dated 04/17/2024, of less than 3, a Hepatitis B surface antibody, dated 08/21/2024 of 3, and a Hepatitis B surface antibody, dated 02/20/2025 of less than 3. The Report indicated Hepatitis B vaccination series was given 05/10/2023, 07/17/2023, 08/18/2023, and 04/12/2024. The Report failed to evidence Patient was offered, received or refused a repeat Hepatitis B vaccination series. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #32 should have had a repeat Hepatitis B surface antibody test one month after the Hepatitis B vaccination series was completed and Patient required a repeat Hepatitis B vaccination series to be offered. 14. A Vaccination and Surveillance Report, for Patient #33, indicated a Hepatitis B surface antibody, dated 11/07/2023, of less than 3, a Hepatitis B surface antibody, dated 04/23/2024, of less than 3, and a Hepatitis B surface antibody, dated 04/01/2025 of 3. The Report indicated Patient received a Hepatitis B vaccine on 11/29/2022, 01/03/2023, and 07/22/2023. The Report failed to evidence Patient was offered, received, or refused a repeat Hepatitis B vaccination series. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #33 should have been offered a repeat Hepatitis B vaccination series. 15. A Vaccination and Surveillance Report, for Patient #34, indicated a Hepatitis B surface			

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	antibody, dated 02/07/2025, of less than 3. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccination. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #34 needed to be offered a Hepatitis B vaccination. 16. A Vaccination and Surveillance Report, for Patient #35, indicated a Hepatitis B surface antibody, dated 05/24/2024, of less than 3, and a Hepatitis B surface antibody, dated 02/21/2025, of less than 3. The Report failed to evidence a Hepatitis B vaccine was offered, received, or refused. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #35 should of had a Hepatitis B vaccination series offered. 17. A Vaccination and Surveillance Report, for Patient #36, indicated a Hepatitis B surface antibody, dated 12/01/2023, of less than 3, a Hepatitis B surface antibody, dated 04/17/2024, of less than 3, and a Hepatitis B surface antibody, dated 02/21/2025, of less than 3. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccination. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #36 should have had a Hepatitis B vaccination series offered. 18. A Vaccination and Surveillance Report, for Patient #37, indicated a Hepatitis B surface antibody, dated 10/30/2023, of less than 3, a Hepatitis B surface antibody, dated 04/17/2024, of less than 3 and a Hepatitis B surface antibody, dated 02/21/2025, of less than 3. The Report indicated one Hepatitis B vaccination was given			

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	on 10/02/2023. The Report failed to evidence the full Hepatitis B vaccination series was offered, received, or refused. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #37 should be offered a Hepatitis B vaccination series. 19. A Vaccination and Surveillance Report, for Patient #38, indicated a Hepatitis B surface antibody, dated 12/05/2024, of less than 3, and a Hepatitis B surface antibody, dated 02/20/2025, of less than 3. The Report failed to evidence Patient was offered, received, or refused the Hepatitis B vaccination. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #38 should be offered a Hepatitis B vaccination series. 20. A Vaccination and Surveillance Report, for Patient #39, indicated a Hepatitis B surface antibody, dated 03/03/2023, of less than 3, a Hepatitis B surface antibody, dated 10/19/2024, of 11, and a Hepatitis B surface antibody, dated 02/20/2025, of 4. The Report failed to evidence Patient received, was offered, or refused the Hepatitis B vaccination. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #39 should be offered a Hepatitis B vaccination series. 21. A Vaccination and Surveillance Report, for Patient #40, indicated a Hepatitis B surface antibody, dated 08/29/2024, of less than 3, and a Hepatitis B surface antibody, dated 02/20/2025, of less than 3. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccination.			

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	During an interview, on 04/23/2025, beginning at 1:30 PM, RN 1 indicated Patient #30 should be offered a Hepatitis B vaccination series. 22. A Vaccination and Surveillance Report, for Patient #41, indicated a Hepatitis B surface antibody, dated 04/18/2024, of 10, and a Hepatitis B surface antibody, dated 02/20/2025, of 8. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccination. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #41 needed to be offered a Hepatitis B booster vaccination. 23. A Vaccination and Surveillance Report, for Patient #42, indicated a Hepatitis B surface antibody, dated 02/22/2024, of 8, and a Hepatitis B surface antibody, dated 04/18/2024, of 5. The Report failed to evidence Patient was offered, received, or refused a Hepatitis B vaccination/booster. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated Patient #42 needed to be offered a Hepatitis B vaccination series.			
V 0128 Bldg. 00	494.30(a)(1)(i) IC-HBV-ISOLATION (EXISTING FACILITY) Based on observation and interview, the dialysis facility failed to ensure an isolation room waiver was obtained, in 1 of 1 ESRD provider which existed before October 14, 2008 and is without an isolation room or area. Findings include:	V 0128	This facility was constructed and certified by Centers for Medicare and Medicaid Services (CMS) prior to February 9, 2009. The facility has never had a dedicated isolation room, nor have they expanded their treatment area, and has not provided hemodialysis care for a patient with Hepatitis B.	05/24/2025

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	During observation of the providers' facility, beginning with the flash tour on April 20, 2025, no isolation room or area was identified in which to provide hemodialysis in a patient with Hepatitis B. During an interview, on 04/22/2025, beginning at 8:45 AM, Corporate Staff 2 indicated the facility did not have an isolation room waiver and was unaware one was required.		The facility has a current agreement with a sister facility, within ten (10) miles of this facility, for provision of hemodialysis services for patients with Hepatitis B. This facility has not expanded their treatment area after February 9, 2009. In accordance with CMS FAQ'a: "If an existing facility expands the treatment area (move at least one wall) or relocates (changes physical location, it would need to add an isolation room or get a waiver from CMS.". Based on guidance from CMS, this facility does not require an isolation room or waiver. If the facility should expand their treatment area or add stations, a request for a waiver will be submitted to CMS.	
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS Based on observation, and interview, the dialysis facility failed to ensure the staff demonstrated aseptic techniques when dispensing and administering intravenous medications from vials in 1 of 1 observations of heparin multi-dose vial dispensing (PCT 3). Findings include: 1. During an observation, on 04/22/2025, beginning at 11:00 AM, PCT 3 did not clean the top of a heparin (blood thinner) multi-dose vial, for Patient #15, and inserted a syringe to draw up the heparin, PCT 3 then inserted another syringe	V 0143	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-06-01 "Medication Policy". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) All teammates administering medications must utilize aseptic technique. 2) An aseptic environment and aseptic technique	05/24/2025

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	to draw up a 2nd syringe of heparin and did not clean the top of the heparin multi-dose vial prior to insertion of the syringe. 2. During an interview, on 04/22/2025, beginning at 2:20 PM, PCT 3 indicated heparin vials should be cleaned prior to drawing up medication in a syringe.		is used when preparing medications. The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0146 Bldg. 00	494.30(c)(2) IC-CATHETERS:GENERAL Based on observation, record review, and interview, the dialysis facility failed to ensure staff	V 0146	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical	05/24/2025

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	followed standard infection control precautions to prevent catheter related infections when providing central venous catheter [CVC] (catheter into vein) access care for hemodialysis [HD] (a process to filter the blood of a patient whose kidneys do not work normally) in 1 of 2 CVC exit site care observed (Patient #16). Findings include: 1. A revised policy, dated October 2024, titled, "Central Venous Catheter [CVC] With Clearguard HD Antimicrobial End Caps Procedure," indicated the exit site would be cleaned with chlorhexidine swab in a back-and-forth pattern from the insertion site to the periphery using both sides of the swab. 2. During an observation, on 04/22/2025, beginning at 11:15 AM, PCT 3 was performing CVC exit site care at Station #7 with Patient #16. During the observation, PCT 3 cleaned the CVC exit site with an antiseptic swab from the exit site to the outside and then cleaned the outside and completed the cleaning at the exit site. 3. During an interview, on 04/22/2025, beginning at 2:20 PM, PCT 3 indicated CVC site care should include cleaning the exit site with a chloraprep (antiseptic) swab from the inside to the outside.		teammates on Policy 1-04-02B "Central Venous Catheter (CVC) With CLEARGUARD HD Antimicrobial End Caps Procedure" starting 04/28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) clean exit site with 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol swab for a minimum of 30 seconds, apply to the CVC exit site in a "back and forth" pattern, using gentle friction progressing from the insertion site to the periphery using both sides of the swab. The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress,	

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			as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0196 Bldg. 00	494.40(a) CARBON ADSORP-MONITOR, TEST FREQUENCY Based on observation, record review, and interview, the dialysis facility failed to ensure staff were able to correctly perform chlorine testing (PCT 3). Findings include: 1. A revised policy, dated October 2024, titled, "Daily Water System Total Chlorine Monitoring," indicated total chlorine testing was done daily prior to the use of the dialysis quality water for dialysis treatments. The policy indicated samples for total chlorine testing were to be drawn from the sample port located downstream of the first (primary) carbon tank or set of tanks in facilities having series connected banks of carbon filters. 2. During an observation, on 04/21/2025, beginning at 3:20 PM, PCT 3 conducted a chlorine water test by drawing a sample from sample port 2 prior to the primary carbon tank and failed to draw a sample from sample port 3 in between the primary and secondary carbon tank.	V 0196	The Facility Administrator, Clinical Coordinator, or Biomedical Specialist will in-service all clinical teammates on Policy 1-18-02 “Daily Water System Total Chlorine Monitoring” starting 04/28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Total Chlorine testing is done on a daily basis prior to the use of dialysis quality water for any process and the start of dialysis treatment(s)…2) Samples for Total Chlorine testing are drawn from the sample port located downstream of the first (primary) carbon tank or set of tanks in facilities having series-connected banks of carbon filters. The Facility Administrator, Clinical	05/24/2025

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	3. A Multi-Station Basic Components and Monitoring of Dialysis Quality Water Treatment Systems Skills Verification for Teammates who perform water monitoring and testing for PCT 3, dated 06/02/2024, indicated PCT 3 verbalized reason for total chlorine testing and satisfactorily located the appropriate sample collection valves for total chlorine water samples on the facility's water system. 4. During an interview, on 04/22/205,beginning at 10:15 AM, biomedical technician 1 indicated manual chlorine testing was to be completed every AM, and the sample should be taken from sample port 3 between the primary and secondary carbon tank.		Coordinator, or Biomedical Specialist will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0470 Bldg. 00	494.70(c) PR-RIGHTS POSTED,STATE/NW ONTACT INFO Based on observation, and interview, the dialysis facility failed to ensure Patients' Rights were posted where it could be easily seen and read by patients in 1 of 1 facility.	V 0470	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 3-01-07 “Patient Rights Patient’s Standards of Conduct,	05/24/2025

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	Findings include: 1. During an observation upon entrance to the dialysis facility, on 04/21/2025, beginning at 9:45 AM, the lobby failed to evidence posting of Patient's Rights. 2. During an interview, on 04/21/2025, beginning at 1:50 PM, the Facility Administrator, Administrative Staff 1, indicated the Patient's Rights should have been posted in the lobby of the facility and were not posted.		Responsibilities, and Facility Rules" and Policy 3-01-07A "Patient Rights" starting 04/28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility will prominently display a copy of the patient rights in the facility…On 042125, the Facility Administrator posted a copy of "Patient Rights Patient's Standards Of Conduct, Responsibilities, and Facility Rules" and "Patient Rights" in a prominent area in the facility lobby. The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits daily x 2 weeks, weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for	

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			effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS Based on record review, and interview, the dialysis facility failed to ensure staff administered Patients' prescribed hemodialysis prescription in order to manage Patients' volume status in 4 of 6 in-center hemodialysis [HD](a process to filter the blood of a patient whose kidneys do not work normally) clinical records reviewed (Patient #1, Patient #3, Patient #4, Patient #5). Findings include: 1. A revised policy, dated April 2024, titled, "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment," indicated patient data would be obtained and documented by the PCT or a nurse. The policy indicated patient prescription and machine settings are verified by staff prior to initiation of treatment and the blood flow rate [BFR] which would be verified and documented when the ordered rate was obtained after onset of treatment. The policy indicated the prescription components were to be confirmed by a nurse within one hour of treatment initiation and would include but not limited to ultrafiltration rate [UFR] (amount of fluid being removed), and BFR. The policy indicated any abnormal findings outside of physician ordered	V 0543	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring, And Nursing Assessment” starting on 4/28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Patient data will be obtained and documented by the patient care technician (PCT) or a licensed nurse. 2) Patient…prescription and machine settings are verified by teammate prior to initiation of treatment with the exception of blood flow rate which is verified and documented when the ordered rate is obtained after onset of treatment. 3) The prescription components are confirmed by a licensed nurse within one (1) hour of treatment initiation…4)	05/24/2025

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	parameters would be documented and reported to the nurse, and if abnormal findings were reported to the nurse pre-treatment, the nurse would assess the patient prior to initiation of dialysis. The policy indicated intradialytic treatment monitoring and data collection would include but not limited to blood pressure, BFR, fluid removal and or replacement, and if the dialysis prescription was not being met including DFR or change to or inability to obtain BFR the reason would be documented and the nurse informed. The policy indicated abnormal findings that would be reported to the nurse included but not limited to predialysis systolic blood pressure greater than 180 or less than 90, or diastolic blood pressure greater than 100 or less than 50, and intradialytic systolic blood pressure greater than 180 or less than 90, and signs and symptoms of hypotension (low blood pressure) to include nausea and vomiting. 2. An undated PCT Job Description indicated technician duties would include but not limited to monitoring patients, before, during and after dialysis treatment including measuring and record stats, patient observations, and HD machine set up. 3. A Dialysis Order, dated 03/19/2025, for Patient #3, indicated the BFR was 450 milliliters/minute (ml/min) and the DFR was 800 ml/min. A Treatment Details Report, dated 03/20/2025, indicated during HD treatment from 6:30 AM until 8:34 AM the DFR was documented as 0. A Treatment Details Report, dated 03/21/2025, indicated from start of HD treatment at 5:57 AM until end of treatment at 8:21 AM the BFR was at 400 ml/min and failed to evidence documentation		Prescription components include but are not necessarily limited to: UFR… Blood flow rate. 4) Any abnormal findings or findings outside of any patient specific physician ordered parameters discovered during pre-treatment data collection will be documented and immediately reported to the licensed nurse…5) If an abnormal finding is reported to the licensed nurse pre-treatment, the nurse will assess the patient prior to the initiation of dialysis. 6) Intradialytic treatment monitoring and data collection which may be performed by the PCT or licensed nurse includes: … Blood pressure… Blood and dialysate flows… Fluid removal and/or replacement…7) If the dialysis prescription is not being met (including dialysis flow rate or change to /inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed. ABNORMAL FINDINGS: … Blood pressure: Pre-dialysis: Systolic greater than 180 mm/Hg or less than 90 mm/Hg • Diastolic greater than or equal to 100 mm/Hg or less than 50 mm/Hg. Blood Pressure-Intradialytic: Systolic greater than 180 mm/Hg or less than 90 mm/Hg… Signs/symptoms of hypotension may include: Nausea and vomiting…The Facility Administrator, Clinical	

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	of the reason the BFR was not as prescribed. During an interview, on 04/24/2025, beginning at 1:30 PM, RN 1 indicated the PCT should have documented the reason the BFR was not administered as prescribed. 4. A Dialysis Order, dated 03/22/2025, for Patient #4, indicated the BFR was prescribed at 400 ml/min and the DFR was prescribed at 800 ml/min. A Treatment Details Report, dated 03/28/2025, indicated Patient started treatment at 10:48 AM with a DFR at 800 ml/min and at 11:00 AM until end of treatment at 2:37 PM the DFR was at 600 ml/min and failed to evidence documentation the reason the DFR was not as prescribed. During an interview, on 04/24/2025, beginning at 2:00 PM, RN 1 indicated the PCT should have documented the reason for the change in the DFR. A Treatment Details Report, dated 04/14/2025, indicated treatment parameter orders were to not initiate HD treatment and notify the nurse for pre-assessment diastolic blood pressure above 120. The Treatment Report indicated at 10:50 AM HD treatment was initiated with a blood pressure of 158/121 and failed to evidence documentation the nurse was notified of the blood pressure. During an interview, on 04/24/2025, beginning at 2:00 PM, RN 1 indicated PCTs are to follow the blood pressure parameters to notify the nurse and the PCT should document that the nurse was notified of the blood pressure was out of parameters. A Treatment Details Report, dated 04/16/2025, indicated treatment parameter orders were to not		Coordinator, or Registered Nurse will audit twenty five percent (25%) of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly with ten percent (10%) of treatment detail reports audited monthly x 3 months during the internal medical records audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	initiate HD treatment and notify the nurse for pre-assessment diastolic blood pressure above 120. The Treatment Report indicated at 10:36 AM HD treatment was initiated with a blood pressure of 200/126 and failed to evidence documentation the nurse was notified of the blood pressure, and at 11:00 AM the blood pressure was 210/130 and failed to evidence documentation the nurse was notified of the blood pressure. The Treatment Report indicated at 2:00 PM Patient complained of nausea and the ultrafiltration profile was ended and failed to evidence the nurse was notified of Patient's complaints or the change in the ultrafiltration profile. The Treatment Report indicated at 12:00 PM the DFR was at 700 until end of HD treatment at 2:45 PM and failed to evidence documentation of the reason the DFR was not as prescribed. During an interview, on 04/24/2025, beginning at 2:00 PM, RN 1 indicated the PCT should notify the nurse and document when the patient's blood pressure were outside of the parameters, the PCT should notify the nurse and document and patient complaints, and the DFR change from the prescribed dialysis order should be documented and reported to the nurse due to a possible TMP problem for the machine to be addressed by biomed. 5. A Dialysis Order, dated 02/05/2025, for Patient #5, indicated a DFR of 800 ml/min. A Treatment Details Report, dated 02/24/2025, indicated the DFR was at 800 at start of HD treatment at 10:46 AM and at 11:30 AM until 2:00 PM the DFR was at 600 and failed to evidence documentation of the reason the prescribed DFR was not given.			

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	During an interview on 04/24/2025, beginning at 2:00 PM, RN 1 indicated the DFR was decreased due to a TMP and the PCT should have documented the reason the DFR was decreased. A Treatment Details Report, dated 02/28/2025, indicated at 1:30 PM Patient's blood pressure was 88/57 and at 1:35 PM Patient's blood pressure was at 64/33, and Patient was symptomatic, ultrafiltration was turned off and 200 ml of fluid was given and failed to evidence documentation the nurse was notified. During an interview on 04/24/2025, beginning at 2:00 PM, RN 1 indicated the PCT should notify the nurse and document the notification when a patient was symptomatic or required interventions. A Treatment Details Reports, dated 03/13/2025, indicated at 12:59 PM Patient's blood pressure was 83/50 and at 1:10 PM Patient complained of cramping and trouble breathing and failed to evidence documentation the nurse was notified of the Patient's symptoms, at 1:25 PM the HD treatment was terminated with a blood pressure of 142/135 and a note by RN 1 was documented at 2:25 PM blood pressure at 142/72 and Patient came off HD treatment early due to stomach pain. During an interview, on 04/24/2025, beginning at 2:00 PM, RN 1 indicated the PCT should notify the nurse and document the notification when a patient was symptomatic. 6. A Dialysis Order, dated 03/27/2025, for Patient #1, indicated the BFR was prescribed at 400 ml/min. A Treatment Details Report, dated 04/02/2025,			

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	indicated BFR at 300 from 7:05 AM to 8:03 AM and the BFR was at 350 from 8:04 AM until end of HD treatment at 9:56 AM. The Report failed to evidence documentation of the reason why Patient did not have the prescribed BFR. A Treatment Details Report, dated 04/04/2025, indicated BFR at 300 from 8:55 AM to 8:59 AM and the BFR was at 250 from 9:59 AM to end of HD treatment at 12:59 PM. The Report failed to evidence documentation of the reason why Patient did not have the prescribed BFR. A Treatment Details Report, dated 04/05/2025, indicated BFR at 400 from 7:57 AM to 7:59 AM and the BFR was at 350 from 8:30 AM until end of HD treatment at 10:37 AM. The Report failed to evidence documentation of the reason why Patient did not have the prescribed BFR. During an interview on 04/24/2025, beginning at 2:00 PM, RN 1 indicated PCTs should document if the BFR was changed due to central venous catheter (catheter into a large vein).			
V 0551 Bldg. 00	494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS Based on observation, record review, and interview, the dialysis facility failed to ensure staff assessed patients' hemodialysis [HD] (a process to filter the blood of a patient whose kidneys do not work normally) access to prevent access failure in 3 of 3 initiations of HD with an arteriovenous fistula [AVF] or arteriovenous graft [AVG] (HD access) (PCT 2 and PCT 4). Findings include:	V 0551	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-04-01 “Arteriovenous Fistula (AVF) And Arteriovenous Graft (AVG) Vascular Access Care” starting on 28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with	05/24/2025

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	1. A revised policy, dated April 2025, titled, "Arteriovenous Fistula and Arteriovenous Graft Vascular Access Care," indicated inspection of the access and access extremity should be performed each dialysis, pre, during and post treatment. The policy indicated inspection of the AVF or AVG would include presence/absence of thrill [felt vibration sensation] and or bruit [swishing sound] heard through a stethoscope. 2. During an observation, on 04/21/2025, beginning at 10:15 AM, PCT 2 was initiating HD using an AVF/AVG site at Station #7 for Patient #14. During the observation, PCT 2 cannulated (inserted needles) without auscultating (listening with a stethoscope) the access site for a bruit. 3. During an observation, on 04/21/2025 beginning at 10:45 AM, PCT 2 initiated HD using an AVF/AVG site at Station #6 for Patient #4. During the observation, PCT 2 cannulated the AVF/AVG without auscultating the access site for a bruit. 4. During an observation, on 04/21/2025 beginning at 10:40 AM, PCT 4 was initiating HD using an AVF/AVG site at Station #4 with Patient #13. During the observation, PCT 4 cannulated the AVF/AVG without auscultating the access site for a bruit. 5. During an interview, on 04/21/2025 beginning at 11:35 AM, PCT 2 indicated AVF site assessment should include palpating (touching) the site and auscultating the site with a stethoscope.		emphasis on, but not limited to the following: 1) Inspection of the AVF or AVG access includes the following: Presence/absence of thrill and/or bruit…2) Inspection of the access and access extremity should be performed each dialysis pre, during and post treatment. The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits for assessment of AVF and AVG access daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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V 0726 Bldg. 00	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE Based on observation, record review, and interview, the dialysis facility failed to ensure medical records were accurate and complete in 3 of 3 arteriovenous fistula [AVF]/arteriovenous graft [AVG] (dialysis access) initiations observed (Patient #4, Patient #13, Patient #14) and in 1 of 1 AVF/AVG adverse event observed (Patient #6). Findings include: 1. A revised policy, dated April 2025, titled, "Arteriovenous Fistula [AVF] and Arteriovenous Graft [AVG] Vascular Access Care," indicated inspection of the AVF and AVG included assessment of the presence/absence of thrill (felt vibration sensation) and/or bruit (swishing sound heard through stethoscope), and presence of swelling. The policy indicated findings and interventions would be documented in the patient's electronic health record. 2. An undated PCT Job Description indicated PCT duties would include monitoring patients including measuring and recording stats, and patient observations. 3. During an observation, on 04/21/2025, beginning at 10:45 AM, PCT 2 initiated HD using an AVF/AVG site at Station #6 for Patient #4. During the observation, PCT 2 cannulated the AVF/AVG without auscultating the access site for a bruit. A Treatment Details Report, dated 04/21/2025, indicated PCT 2 assessed that the AVF had a continuous bruit and thrill.	V 0726	The Facility Administrator, Clinical Coordinator, or Registered Nurse will in-service all clinical teammates on Policy 1-04-01 “Arteriovenous Fistula (AVF) And Arteriovenous Graft (AVG) Vascular Access Care” starting on 28/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Inspection of the AVF or AVG access includes the following: Presence/absence of thrill and/or bruit… Presence of swelling or edema • Signs and symptoms of infection, including temperature, redness, pain, swelling, drainage 2) Inspection of the access and access extremity should be performed each dialysis pre, during and post treatment. 3) Document findings and interventions in patient’s electronic health record. The Facility Administrator, Clinical Coordinator, or Registered Nurse will conduct observational audits for assessment of AVF and AVG site and access extremity daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal audit. The Facility	05/24/2025

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	4. During an observation, on 04/21/2025, beginning at 10:40 AM, PCT 4 was initiating HD using an AVF/AVG site at Station #4 with Patient #13. During the observation, PCT 4 cannulated the AVF/AVG without auscultating the access site for a bruit. A Treatment Details Report, dated 04/21/2025, indicated PCT 4 assessed that the AVF had a continuous bruit and thrill. 5. During an observation, on 04/21/2025, beginning at 10:15 AM, PCT 2 was initiating HD using an AVF/AVG site at Station #7 for Patient #14. During the observation, PCT 2 cannulated (inserted needles) without auscultating (listening with a stethoscope) the access site for a bruit. A Treatment Detail Report, dated 04/21/2025, indicated PCT 2 assessed that the AVF had a continuous bruit and thrill. 6. During an observation, on 04/21/2025, beginning at 11:05 AM, PCT 3 was at Station #14 with Patient #6. During the observation, Patient's left arm was observed to be swollen from the left upper arm to wrist area, and PCT 3 cannulated (inserted needles) for 2 lines to the AVF site. During the observation, Patient complained of pain to the left arm insertion sites and RN 1 assessed Patient. During an interview, on 4/24/2025, beginning at 2:40 PM, the Facility Administrator, Administrative Staff 1, indicated there was not documentation of Patient #6's 04/21/2025 treatment record in Patient's electronic medical record because dialysis treatment was not started.		Administrator, Clinical Coordinator, or Registered Nurse will audit twenty five percent (25%) of treatment detail reports daily for two (2) weeks, then weekly for two (2) weeks to verify compliance with facility policy for documentation of abnormal findings and interventions. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports audited monthly x 3 months during the internal medical records audits. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	During an interview, on 04/24/2025, beginning at 2:00 PM, RN 1 indicated he should have documented Patient #6's short treatment and complaints of pain and swelling at the AVF site.			