STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152659	A. BUILDING _____ B. WING _____	C 08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BEND WEST DIALYSIS	5660 NIMTZ PKWY SOUTH BEND, IN 46628

(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 000	INITIAL COMMENTS This visit was for a Federal complaint survey of an ESRD supplier. Survey Date: 8/5/2022, 8/8/2022 Complaint: IN00365883 - Unsubstantiated, Unrelated Federal deficiencies were cited. Complaint: IN00355636 - Unsubstantiated, Federal deficiencies were not cited. ICHD Census: 54 Total Census: 54 Isolation Room: 1 QR: Area 2, 8/17/22	V 000		
V 113	IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on document review, observation, and interview, the agency failed to ensure hand hygiene procedures were followed in 2 of 2 observation days, with the potential to affect all patients and ESRD staff [patient care technician [PCT] #2, 3, 4, and 5]. Findings include:	V 113	V113 The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities" starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area. 2) Alcohol-based hand rubs may be used: …Before gloving and after glove Continued on page 2	9/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 113	Continued From page 1 1. Review of an agency policy titled "Infection Control for Dialysis Facilities," policy 1-05-01, indicated but was not limited to " ... hand hygiene ... prior to gloving, after removal of gloves ..." and " ... Alcohol-based hand rubs [ABHR] ... Before gloving and after glove removal ...." 2. During an observation period beginning on 8/5/2022, beginning at 9:25 AM, observed staff completing hand hygiene, individuals who washed their hands at the identified sink were unable to retrieve a paper towel without touching the trash can liner of the trash can, which was underneath the paper towel dispenser. The trash can was without a lid. A. During an interview on 8/5/2022 at 1:31 PM, the Administrator confirmed it was not possible to complete an appropriate hand wash due to the location of the trash can below the paper towel dispenser. B. During an observation on 8/5/2022 at 10:02 AM, PCT 4 completed a 3 second ABHR and waved her hands to dry. C. At 10:03 AM, PCT 3 was observed to write the date on Patient #4's central venous catheter [CVC] dressing, then observed to complete a 4 second ABHR, then donned gloves and removed gauze from the CVC lines. PCT 3 removed one glove, with the gloved hand they then picked up empty supply wrappers from the clean work area. PCT 3 then removed glove and completed a 5 second ABHR, then charted on the computer. After charting, PCT 3 completed a 10 second ABHR prior to escorting a patient into the treatment area.	V 113	V113 Continued from page 1 removal. Ton 8/5/22, the Facility Administrator moved the tall trash in front of the paper towel dispenser at the clean sink and replace with a shorter trash can to prevent contamination of teammates' hands when removing paper towels from the holder. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	

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V 113	Continued From page 2 D. At 10:14 AM, PCT 2 was observed to complete a pH check of the dialysis machine. PCT 2 then removed their gloves and performed a 5 second ABHR prior to using the computer. E. At 10:15 AM, PCT 4 completed a 7 second ABHR, donned gloves and put a blood pressure cuff on Patient #19. PCT 4 removed gloves, completed a 6 second ABHR, then waved hands in the air to dry. After donned gloves, PCT 4 repositioned the blood pressure cuff. F. At 10:26 AM, observed PCT 2 complete a 4 second ABHR, don gloves, then cleaned the CVC access site for Patient #3. G. At 12:55 PM, PCT 3 was observed touching hair while adjusting their face shield (eye protection). PCT 3 then donned clean gloves to attend to Patient #4. PCT 3 attached a saline syringe to the arterial line of Patient #4's CVC. PCT removed gloves, completed an 11 second ABHR and donned new gloves and then attached a saline syringe to the venous line of Patient #4's CVC. PCT 3 removed gloves, completed ABHR for 6 seconds and removed both saline syringes from Patient #4's CVC. 3. During an observation on 8/8/2022 at 11:16 AM, after attending to Patient #20, PCT 5 was observed to complete a 6 second ABHR and applied clean gloves. PCT 5 put a blood pressure cuff on Patient #8 and checked the pH of the dialysis machine. PCT 5 then assembled supplies and prepared the lab tubes. PCT 5 removed gloves and completed a 5 second ABHR, then used the computer. PCT 5 completed a 3 second ABHR before donned	V 113		

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V 113	Continued From page 3 clean gloves. PCT 5 then went to Patient #20 and taped the dressing on the access site. 4. While with Patient #8, PCT 5 adjusted the dialyzer and assessed Patient #8's access site using both a stethoscope and his/ her hand. PCT 5 removed gloves, completed a 3 second ABHR and donned new gloves. PCT 5 then removed the dialyzer and tubing from Patient #20's vacated machine. PCT 5 completed a 3 second ABHR. When returned to Patient #8, PCT 5 completed a 4 second ABHR before donned new gloves. After cleaning Patient #8's access site, PCT 5 completed a 3 second ABHR. After donned new gloves, PCT 5 attached needles and tubing to Patient #8's access site. PCT 5 removed gloves and completed a 3 second ABHR then used the computer. 5. During an interview on 8/5/2022 at 1:31 PM, the Administrator described the hand hygiene expectations as using ABHR before donning or after removing gloves The Administrator confirmed ABHR was to be used prior to and after using the computer; no gloves were to be worn while using the computer. The Administrator further confirmed that waving hands to dry them was not appropriate. 6. During an interview on 8/8/2022 at 2:30 PM, the Administrator confirmed the hand hygiene process was as described on 8/5/2022.	V 113		
V 117	IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS CFR(s): 494.30(a)(1)(i) Clean areas should be clearly designated for the preparation, handling and storage of medications	V 117	V117 The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 "Infection Control For Dialysis Facilities" starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates Continued on page 5	9/17/22

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V 117	Continued From page 4 and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the ESRD provider failed to ensure medication, supplies, and intradialytic parenteral nutrition (IDPN, nutrition supplied through the venous line) were kept in the packaging, in a clean area prior to use in 2 of 2 observation days, with the potential to affect all patients. Findings include: 1. Review of an agency policy titled "Infection Control for Dialysis Facilities," policy 1-05-01, indicated but was not limited to " ... will not handle and store medications or clean supplies ... where used equipment or blood samples are handled ...." The policy further stated "... supplies, such as saline ... will not be opened until time of use...."	V 117	V117 Continued from page 4 signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Teammates will not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. 2) Disposable supplies, such as saline…will not be opened until time of use. On 8/5/22, the Facility Administrator removed the clean supplies from the dirty area. On 8/17/2022 a plexiglass barrier was placed on the counter next to the laboratory area (including blood vials and centrifuge) to provide a barrier between clean and dirty areas to prevent cross contamination. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	

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V 117	Continued From page 5 2. During an observation on 8/5/2022 at 9:25 AM, two plastic storage containers with open lids were observed on the counter near the blood vials and centrifuge (machine that spins the vials prior to the test). One container held needles and the other contained adapters to draw blood from a venous line. Additionally, IDPN for Patient #8 was on the same counter, in front of the blood vials. 3. During an interview on 8/5/2022 at 1:31 PM, the Administrator confirmed medication, IDPN, and clean supplies were not allowed on the counter near the centrifuge. 4. During an observation on 8/8/2022 at 1:12 PM, an open vial of Heparin was observed on the medication work counter. Approximately 1/3 of the medication remained in the vial. The vial did not have a date opened written on the vial. The Administrator was queried about the vial and confirmed the vial lacked the required date opened notation. 5. During an observation on 8/8/2022 at 1:13 PM, a saline syringe which was removed from the packaging was observed on the counter of Pod 1. 6. During an interview on 8/8/2022 at 2:30 PM, the Administrator confirmed supplies were considered clean if in the packaging.	V 117		
V 121	IC-HANDLING INFECTIOUS WASTE CFR(s): 494.30(a)(4)(i) [The facility must demonstrate that it follows standard infection control precautions by implementing-]	V 121	V121 The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates Continued on page 7	9/17/22

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V 121	Continued From page 6 (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the- (i) Handling, storage and disposal of potentially infectious waste; This STANDARD is not met as evidenced by: Based on document review, observation, and interview, the agency failed to ensure staff used syringes and needles were not placed in a full sharps container in 1 of 2 observation days, with the potential to affect all patients [PCT 2]. Findings include: 1. Review of an agency policy titled "Infection Control for Dialysis Facilities," policy 1-05-01, indicated but was not limited to " ... sharps containers that are 3/4th's full will be removed from the treatment area ...." 2. During an observation on 8/5/2022 at 9:56 AM, a sharps container displaying the word "Full" was seen on the treatment floor. 3. During an observation on 8/5/2022 at 10:37 AM, Patient Care Technician (PCT) 2 was observed with Patient #3. After PCT #2 used a syringe and needle, PCT 2 disposed of the syringe and needle into the full sharps container. 4. During an interview on 8/5/2022 at 1:31 PM, the Administrator confirmed the sharps container was full when the word "Full" was displayed.	V 121	V121 Continued from page 6 signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) …sharp containers that are 3/4ths full will be removed from the treatment area and placed in the labeled designated area and locked, to await transport to the licensed disposal site. On 8/5/22, the Facility Administrator removed the “full” sharps container from the treatment area and placed In the Biohazard storage room. The “full” sharps container was replaced with an empty sharps container. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	
V 122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL	V 122	V122 The Facility Administrator or designee will in- Continued on page 8	9/17/22

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V 122	Continued From page 7 CFR(s): 494.30(a)(4)(ii) [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based on document review, observation, and interview, the agency failed to ensure their staff stored the daily 1:100 bleach disinfectant solution, used for the decontamination of the dialysis stations and equipment, in a manner that prevented loss of the disinfectant properties in 2 of 2 observation days, with the potential to affect all patients. Findings include: 1. Review of an agency policy titled "Infection Control for Dialysis Facilities," policy 1-05-01, indicated but was not limited to " ... Use an appropriate disinfectant such as 1:100 ... bleach solution ..." or " ... a 1:10 ...bleach solution ...." 2. During an observation on 8/5/2022 at 9:50 AM, 6 containers of bleach solution were observed on the treatment floor; containers labeled 1:10 and 1:100 bleach solution were located at the clean sink in Pod 1. A 1:100 bleach container was located at the dirty sink in Pod 1. Pod 2 had a 1:10 and 1:100 bleach solution at the clean sink. The dirty sink at Pod 2 had a container of 1:100 bleach solution.	V 122	V122 Continued from page 7 service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” and Policy 1-05-08 “Bleach Policy” starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Cleaning and/or disinfection of equipment and work surfaces will be performed as soon as possible following exposure to blood or other potentially infectious materials. Use an appropriate disinfectant such as 1:100 (one to one hundred) bleach solution for environmental surfaces. For visible blood or gross blood spills, a 1:10 (one to ten) bleach solution must be utilized. 2) Bleach solution needs to be covered with a secure lid and the solution should not be placed in the splash zone. NOTE: Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective. The Facility Administrator or designee will conduct observational audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	

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V 122	Continued From page 8 A. During the observation at 9:50 AM, the bleach containers at the clean sink in Pod 1 and at the dirty sink in Pod 1 were not covered to prevent loss of the disinfectant qualities of the solution. B. During the observation at 10:30 AM, the 1:100 bleach container at the dirty sink in Pod 1 and the container at the clean sink in Pod 1 was uncovered. The 1:10 solution at the clean sink had the lid on top of the container, though ajar and not completed closed. 3. During an observation on 8/5/2022 at 12:25 PM, all bleach containers in Pod 1 were uncovered. At 12:29 PM, the bleach solutions at the clean sink in Pod 2 were uncovered. At 1:10 PM, all bleach containers in Pod 1 were open and uncovered. 4. During an interview on 8/5/2022 at 1:31 PM, the Administrator confirmed all bleach solution must be covered with lid snapped closed. 5. During an observation on 8/8/2022 at 10:58 AM, the bleach containers at the clean sink in Pod 1 were not covered and all of the bleach containers in Pod 2 were uncovered. A. At 11:44 AM, all bleach containers in both Pods were open, uncovered, solution open to the air. B. At 12:59 PM, the bleach solutions at the clean sink in Pod 1 were both open to the air, uncovered. The bleach containers in Pod 2 were uncovered.	V 122		
V 147	IC-STAFF	V 147	V147 The Facility Administrator or designee will in- Continued on oage 10	9/17/22

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V 147	Continued From page 9 EDUCATION-CATHETERS/CATHETER CARE CFR(s): 494.30(a)(2) Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to ensure central venous lines (CVC, a tube that goes in a vein near the heart as part of the	V 147	V147 Continued from page 9 service all clinical teammates on Policy 1-04-02B "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure" starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Using aseptic technique, remove each cap. 2) One at a time, disinfect each CVC hub with a new alcohol prep pad. 3) 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. The Facility Administrator or designee will conduct observational audits for Central Venous Catheter care daily for two (2) weeks then weekly for two (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 immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	

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V 147	Continued From page 10 dialysis process) were cleaned appropriately to reduce the chance of infection in 1 of 2 CVC dialysis initiation observations, with the potential to affect all 10 patients with a CVC (Patient care technician [PCT] #3). Findings include: 1. During an observation, on 8/5/2022 at 10:03 AM, access of Patient #4's CVC for dialysis. PCT 3 scrubbed the arterial hub with an alcohol prep pad for 3 seconds. PCT 3 retrieved a new prep pad and scrubbed the venous line for 5 seconds. PCT 3 returned to scrub the arterial line for 2 seconds while using the same alcohol prep pad. 2. During an observation period on 8/5/2022, no clocks were observed in the treatment area. 3. During an interview on 8/8/2022 at 2:30 PM, the Administrator confirmed there were no clocks on the treatment floor and that staff had no ability to time the CVC scrub. The Administrator further confirmed the scrub should be 20 seconds for each hub and a new alcohol prep pad was to be used for each hub.	V 147		
V 407	PE-HD PTS IN VIEW DURING TREATMENTS CFR(s): 494.60(c)(4) Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to ensure patients' access site was visible to staff on 2 of 2 observation days, with the	V 407	V407 The Facility Administrator or designee will in-service all clinical teammates on Policy 1-03-08 "1 Pre-Intra-Post Data Collection, Monitoring and Nursing Assessment" and Policy 8-04-01 "Physical Environment" starting on 8/19/2022. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. Teammates instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The vascular access site, blood line connections and the Continued on page 12	9/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152659	A. BUILDING _____ B. WING _____	C 08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BEND WEST DIALYSIS	5660 NIMTZ PKWY SOUTH BEND, IN 46628

(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 407	Continued From page 11 potential to affect all patients. Findings include: 1. During an observation period on 8/5/2022 beginning at 12:22 PM, observed Patient #3's access site was covered with a blanket. During the same observation period, Patients #6 and 7 were observed with their access sites covered. Patient #6 was observed with a blanket covering the entire body, including over their head. 2. During an interview, on 8/5/2022 at 12:22 PM, RN 1 indicated an access site was visible if RN 1 could see the blood line tubing. 3. During an interview on 8/5/2022 at 12:40 PM, PCT 1 indicated an access site was visible if the needles were visible or if the CVC lines at the access point were visible. While sitting at the Pod 2 desk, PCT 1 was queried whether Patient # 7's access site was visible. PCT 1 relayed the the site was not visible from the desk. 4. During an interview, on 8/5/2022 at 1:31 PM, the Administrator confirmed the access site should be visible from the desk or when walking around the room and an employee should not need to be at the patient's chair to visualize. The Administrator relayed the access site itself must be visualized. 5. During an observation period on 8/8/2022 at 11:10 AM, Patient #6 was observed with their access site covered.	V 407	V407 Continued from page 11 patient's face should be visible throughout the dialysis treatment. 2) Teammates will be able to visualize patients at all times during hemodialysis treatments for patient safety. The Facility Administrator or designee will conduct observational audits for access site, face, and bloodline connection visibility daily for two (2) weeks then weekly for two (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 immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	