STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152648	A. BUILDING 00 B. WING	01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT WAYNE WEST DIALYSIS	4916 ILLINOIS RD STE 118 FORT WAYNE, IN 46804

(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
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: January 13th and 14th of 2022. Census: 49 In-center hemodialysis 6 Peritoneal Dialysis 2 Home Hemodialysis At this Emergency Preparedness survey, Fort Wayne West Dialysis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR Completed 1/21/2022 A4	E 0000		
V 0000 Bldg. 00	This visit was for a federal core ESRD (Core) recertification survey in conjunction with a COVID-19 infection control focused survey. Survey Dates: January 13th and 14th of 2022 Census: Census: 49 In-center hemodialysis 6 Peritoneal Dialysis 2 Home Hemodialysis	V 0000		
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at			

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

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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	the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation and interview, the facility failed to ensure that staff were changing gloves and washing hands appropriately when soiled in 1 of 4 fistula & graft (accesses used to initiate dialysis) initiations. (Patient 20) Findings Include: 1. A policy titled "AV Fistula or Graft Cannulation with JMS Sysloc Mini Safety Fistula Needles (SFN) And Administration of Heparin Loading Dose," updated April 2019 was provided by the GFA on 1/13/2022 at 2:25 p.m. The policy indicated but was not limited to, "5. Perform inspection, auscultation, and palpation on the entire length of the access. Determine presence of bruit and thrill." 2. During an observation on 1/13/2022 at 9:58 a.m. Employee D was observed discontinuing an AVF (used to access blood for dialysis) on Employee 20. Employee D stopped the process, removed one glove, walked over to the clean supply drawer, with ungloved hand that was not disinfected, pulled out a clean supply, returned to the patient, put on clean glove, and continued to disconnect the patient from treatment. 3. An interview with the administrator was completed on 1/13/2022 at 4:30. The administrator was made aware that Employee D was noted to remove one glove without disinfecting, obtain a clean supply from the drawer at the nurse's station, return to patient, re-apply one clean glove, and continue disconnecting the patient from the blood lines post treatment. The	V 0113	The Facility Administrator or designee held mandatory in-service(s) for all Clinical Teammates on Policy 1-05-01 “Infection Control for Dialysis Facilities” starting on 1/27/2022. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) 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. The Facility Administrator or designee will conduct observational infection control 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 the internal infection control audit. Instances of noncompliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits	02/12/2022

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	administrator agreed that this is not an infection control protocol that should be followed.		with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance Performance Improvement (QAPI) meetings, known as Facility Health Meetings (FHM) with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0116 Bldg. 00	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. Based on observation, record review, and interview, the facility failed to ensure non-dedicated multi-use items were placed in a designated clean or designated dirty area for 2 of 3 dialysis machine set-ups reviewed. (Station 2 & Station 3)	V 0116	The Facility Administrator or designee held mandatory in-service(s) for all Clinical Teammates on Policy 1-05-01 “Infection Control for Dialysis Facilities” and Policy 2-08-01F Phoenix Meter Disinfection and Calibration Verification” starting on	02/12/2022

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	Findings include: A policy titled, "Infection Control for Dialysis Facilities," dated October 2021 was provided by the GFA on 1/13/2022 at 2:45 p.m. The policy indicated but was not limited to, "25. Non-disposable items are to be disinfected between patients ... Clean areas should be clearly designated for ... unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled" A policy titled, "Phoenix Meter Disinfection and Calibration Verification" was provided by the GFA on 1/13/2022 at 2:25 p.m. The policy indicated but was not limited to; "The outside of phoenix meters must be disinfected after use prior to returning the meter to the storage location." During an observation 01/13/3033 at 10:00 a.m., two Phoenix Meters (A syringe-style meter for quick and accurate measurement of conductivity, temperature and pH of a solution.) were observed laying on a common countertop not identified as clean or dirty. During an observation on 1/13/2022 at 10:41 a.m. CCHT K was observed picking up a meter from the counter, taking the meter to dialysis station 2, obtaining a pH and Conductivity reading, and returning the dirty Phoenix Meter to the countertop. During an observation on 1/13/2022 at 11:00 a.m. CCHT K was observed picking up the dirty meter from the counter, taking the meter to dialysis station 3, obtaining a pH and Conductivity reading, and returning the dirty Phoenix Meter to the countertop.		1/27/2022. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Non-disposable item are to be disinfected between patients. 2) Clean areas should be clearly designated for…storage of…unused supplies…3) Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. 4) The outside of phoenix meters must be disinfected after use prior to returning the meter to the storage location. 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 the 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 and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is	

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	During an interview on 1/13/2022 at 4:30 p.m., the administrator was made aware of two phoenix meters placed on counter at nurse's station immediately after use on a patient station and not disinfected. One meter was observed being used at another patient station and not disinfecting prior to use, then returned to nurse's station counter, not disinfected. This was not a designated dirty area. The Administrator indicated staff are supposed to place phoenix meter at dirty sink and is to be disinfected before use with another patient.		responsible for compliance with this plan of correction.	
V 0121 Bldg. 00	494.30(a)(4)(i) IC-HANDLING INFECTIOUS WASTE [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- (i) Handling, storage and disposal of potentially infectious waste; Based on observation and interview, the facility failed to follow proper infection control precautions in handling and disposal of infectious waste in 1 of 1 facility observed. Findings Include: 1. A policy last revised September of 2015 titled "Segregation of Medical Waste" was provided by the GFA on 01/13/2022 at 2:25 p.m. The document indicated, but was not limited to, "1. Medical waste is contained separately from other non-infectious waste generated in the facility. 2. Medical waste containers are defined as: a. A	V 0121	The Facility Administrator or designee held mandatory in-service(s) for all Clinical Teammates on Policy 1-05-01 “Infection Control for Dialysis Facilities” and Policy 4-03-07 “Segregation of Medical Waste” starting on 1/27/2022. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) For visible blood or gross blood spills, a 1:10 (one	02/12/2022

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	labeled plastic container with a foot mechanism to open the lid ... b. A labeled medical waste transfer container with a wheeled base tray and foot mechanism to open the lid. C. A labeled plastic container with no foot mechanism to open the lid ... 4. Labeled medical waste containers should be lined with red bags." 2. During an observation on 1/13/2022 at 10:57 a.m. Employee D was observed cannulating an AVG (arteriovenous graft-used for dialysis access) on Patient 19. A 10 ml (milliliter) syringe was used to check patency of access prior to connecting the blood lines from the dialysis machine. The 10 ml syringe was then placed on the side table of the dialysis chair. Observed blood leak from syringe onto table covering a large area of the table. Employee D then used a clean pad to wipe up the blood spill and then discarded the blood-soaked pad into the regular trash can sitting beside the patients chair instead of the red biohazard container. 3. An interview with the administrator was completed on 1/13/2022 at 4:30 p.m. The administrator agreed that the blood-soaked pad should have been discarded in the red biohazard container, not the regular trash can.		to ten) bleach solution must be utilized. After all visible blood is cleaned with the 1:10 (one to ten) bleach solution, teammates are to use a new disposable towel soaked with 1:10 (one to ten) bleach solution and clean area a second time. 2) Medical waste is contained separately from other non-infectious waste generated in the facility. 3) Medical waste containers are defined as: A labeled plastic container with a foot mechanism to open the lid…A labeled medical waste transfer container with a wheeled base tray and foot mechanism to open the lid; A labeled plastic container with no foot mechanism to open the lid. The Facility Administrator or designee will conduct observational infection control 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 the internal infection control audit. 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 Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes.	

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			The Facility Administrator is responsible for compliance with this plan of correction.	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. Based on observation and interview the facility failed to ensure all staff demonstrated proper infection control procedures for cleaning and disinfection of contaminated surfaces to safeguard against potential transmission of COVID-19 in 8 of 8 observations. (Patient 2, 7, 12, 13, 14, 16, 17, and 18) Findings Include: 1. A policy titled, "Infection Control for Dialysis Facilities," dated October 2021, was provided by Employee P on 1/13/2022 at 2:25 p.m. The policy indicated but was not limited to, "25. Non-disposable items are to be disinfected between patients." ... "71. When cleaning the dialysis station post treatment, CDC recommendations and CMS regulations require the dialysis station be completely vacated by the previous patient before teammates can begin cleaning and disinfection of the station and set up for the next patient."	V 0122	The Facility Administrator or designee held mandatory in-service(s) for all Clinical Teammates on Policy 1-05-01 “Infection Control for Dialysis Facilities” and CMS Memo “QOS-20-20-ALL” starting on 1/27/2022. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including the dialysis delivery system, the interior and exterior of the prime container, the dialysis chair and side tables including opening the chair to reach crevices, blood pressure equipment, television arms and control knobs or remote control devices if accessible to patients and teammates, facility wheel	02/12/2022

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	2. A CMS Memo QSO-20-20-ALL indicated, but was not limited to; "Transmission-Based Precautions ... Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) are used, or if not available, then equipment is cleaned and disinfected according to manufacturers ' instructions using an EPA-registered disinfectant prior to use on another patient or before being returned to a common clean storage area ..." 3. During an observation on 1/13/2022 at 11:21 a.m. Patient 17 was observed sitting in the dialysis chair post treatment gathering his personal belongings post treatment while Employee D began disinfecting the dialysis machine and TV. Once Patient 17 vacated the station, Employee D then continued disinfection of the dialysis chair. 4. On 1/13/2022 at 10:57 a.m., Patient 18 was exited station 6 treatment chair, obtained weight on scale, pushed button for receipt. No hand hygiene was completed prior prior to pushing button on keypad. No disinfection of the contaminated scale surfaces was performed. 5. On 01/13/2022 at 10:10 a.m. patient 12 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 6. On 01/13/2022 at 10:15 a.m. patient 2 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 7. On 01/13/2022 at 10:16 a.m. patient 13 exited the		chairs, outside of sharps containers, IV poles, as well as all work surfaces will be wiped clean with a bleach solution of the appropriate strength after completion of procedures, before being used on another patient…2) Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff…with an appropriate disinfectant after every treatment. 3) When cleaning the dialysis station post treatment, CDC recommendations and CMS regulations require the dialysis station be completely vacated by the previous patient before teammates can begin cleaning and disinfection of the station and set up for the next patient. The Facility Administrator will implement a process for the patients to perform hand hygiene after termination of treatment prior to leaving the dialysis station. The Facility Administrator or designee will conduct observational infection control 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 the internal infection control audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom	

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	treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 8. On 01/13/2022 at 10:19 a.m. patient 7 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 9. On 01/13/2022 at 10:26 a.m. patient 14 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 10. On 01/13/2022 at 10:28 a.m. patient 16 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 11. On 01/13/2022 at 10:35 a.m. patient 15 exited the treatment chair, obtained weight on the scale, pushed the button for receipt. No hand hygiene was performed prior to pushing the button on the scale. No disinfection of the contaminated scale surfaces was performed. 12. An interview with the administrator on 1/13/2022 at 4:30 p.m. was completed. The administrator indicated that disinfection of the scales, the lobby, and doorknobs, essentially high frequency touched areas are disinfected between each patient shift. Once all the patients for shift #1		meetings and with Medical Director during monthly Quality Assurance 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.	

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	are on the dialysis machines, disinfection of these areas are then completed. Again, after shift 2 patients are on treatment, disinfection is completed again. The scale keypad and grab bar are not disinfected between each patient use. The administrator agreed that patients should be vacating stations post treatment before any station disinfection is completed.			
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and Based on record review and interview, the facility failed to ensure a mechanism was in place to ensure expired medication was not available for use or administered to the patient for 1 of 2 intravenous medication observations. (Patient 8) Findings include: An April 2021 revised policy titled "Medication Policy" was provided by the GFA on 1/13/2022 at 2:25 p.m. The policy indicated but was not limited to; " 20. If medications are prepared and administered immediately, by the same licensed nurse teammate, the medications do not need to be labeled. If the medication is not immediately administered or is to be administered by another teammate, the medication must be labeled with patient name, name of the medication, date, time prepared, dose and initials of teammate preparing the medication." During an observation on 1/13/2022 at 9:45 a.m., a	V 0143	The Facility Administrator or designee held mandatory in-service(s) for all Clinical Teammates on Policy 1-06-01 “Medication Policy” starting on 1/27/2022. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If medications are prepared and administered immediately, by the same licensed nurse teammate, the medications do not need to be labeled. If the medication is not immediately administered or is to be administered by another teammate, the medication must be labeled with the patient name, name of medication, date, time prepared, dose and initials of	02/12/2022

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	syringe containing Parasabiv (a medication used for the treatment of secondary hyperparathyroidism), prepared for patient 8, was observed on the counter. The medication label failed to identify who prepared the medication and the date and time the medication was prepared. On 01/14/2022 a document titled "Post Treatment Sheet" dated 01/13/2022 for patient 8 was reviewed. The treatment sheet indicated patient 8 received the undated, untimed, prepared IV medication at 12:42 p.m. During an interview on 01/13/2022, RN (registered nurse) B indicated medications are to be dated, timed, and initialed when prepared in advance.		teammate preparing the medication. The Facility Administrator or designee will conduct observational audits for medication preparation and administration daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the medication audit. 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 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.	
V 0520 Bldg. 00	494.80(d)(2) PA-FREQUENCY REASSESSMENT-UNSTABLE Q MO In accordance with the standards specified in paragraphs (a)(1) through (a)(13) of this section, a comprehensive reassessment of each patient and a revision of the plan of care must be conducted- At least monthly for unstable patients including, but not limited to, patients with the following: (i) Extended or frequent hospitalizations;			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(ii) Marked deterioration in health status; (iii) Significant change in psychosocial needs; or (iv) Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis. Based on record review and interview, the facility failed to ensure the interdisciplinary team completed a comprehensive re-assessment and an updated plan of care deeming the unstable patient as stable and failed to complete a monthly unstable plan of care in 2 of 3 patients reviewed. (Patient 4 and 10) Findings Include: 1. A policy titled, "Interdisciplinary Team (IDT) Patient Assessment and Plan of Care," dated October 2020 was provided by the administrator on 1/14/2022 at 3:12 p.m. The policy indicated but was not limited to, "1. The facilities interdisciplinary team (IDT) consists of, at minimum, the patient or the patient's personal representative, a registered nurse, a physician or Non-Physician Practitioner (NPP), if allowed by state ESRD (End Stage Renal Disease) licensure regulations, treating the patient for ESRD, a social worker, and a dietician." ... "2. The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment will be used to develop the patient's treatment plan and expectations for care." ... "Monthly (unstable patients). Assessment: Monthly until patient is determined by interdisciplinary team to be stable. Plan of Care: Complete patient plan of care meeting within 15 days of the completion of the re-assessment and POC (plan of care)."	V 0520	The Facility Administrator or designee held a mandatory in-service(s) for all Interdisciplinary Team (IDT) members on Policy 1-14-01 “Interdisciplinary Team (IDT) Patient Assessment and Plan of Care”. Verification of attendance will be evidenced by a signature sheet. IDT members will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The facility’s interdisciplinary team (IDT) consists of, at a minimum, the patient or the patient’s personal representative, a registered nurse, a physician or Non-Physician Practitioner (NPP), if allowed by state ESRD licensure regulations, treating the patient for ESRD, a social worker, and a dietitian. 2) The interdisciplinary team is responsible for providing each patient with an individualized and comprehensive assessment documenting his/her needs. The comprehensive assessment will be used to develop the patient’s treatment plan and expectations for care. 3) A comprehensive re-assessment of each patient and a revision in the plan of care will be conducted: … At least monthly for unstable patients including…4)	02/12/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152648	A. BUILDING 00 B. WING	01/14/2022

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	2. A record review was completed for Patient 4 on 1/13/2021 and 1/14/2021. The record indicated the following: Patient 4 was deemed unstable in September of 2021 through November of 2021 indicating the reason as concurrent conditions. In December of 2021 Patient 4 was deemed unstable indicating the reason as hospitalizations. There was no care plan completed after January of 2022 deeming the patient as unstable or stable. 3. A record review was completed for Patient 10 on 1/13/2021 and 1/14/2021. The record indicated the following: Patient 10 was deemed unstable in August of 2021 indicating the reason as hospitalizations. No further re-assessment or plan of care was completed the following 3 months (September, October, & November of 2021) reflecting Patient 10's status of stable or unstable. Patient 10 was again deemed unstable in December of 2021 indicating the reason as psychosocial. No further re-assessment and plan of care was completed the following month deeming Patient 10 as stable or unstable. 4. An interview was completed with the administrator on 1/14/2022 at 3:02 p.m. The administrator was advised of three patients reviewed that were deemed unstable and did not have a follow-up comprehensive re-assessment with the IDT (interdisciplinary team) and an updated plan of care completed reflecting these patients once again as stable. The administrator indicated that he has not been completing a follow up comprehensive assessments including the IDT and updating the care plan as the patient becomes stable for any of the (In-center Hemodialysis) ICHD patients after being deemed unstable. He		Monthly (unstable patients) – Assessment: Monthly until patient is determined by interdisciplinary team to be stable – Plan of Care: Complete patient plan of care meeting within 15 days of the completion of the re-assessment and POC. The IDT will complete a re-assessment for Patients #4 and #10 by 2/12/22 to determine stable/unstable status. A patient plan of care meeting will be completed within 15 days of the completion of the re-assessment and POC for Patients #4 and #10. The Facility Administrator or designee will audit 100% of unstable Plans of Care monthly x 3 months to verify compliance with facility policy. Ongoing compliance will be verified with 10% of unstable Plans of Care audited monthly x 3 months. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with the Interdisciplinary Team during IDT meetings and with Medical Director during monthly Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	was unaware of the need to. Indicated that the nurses' complete assessments prior to each hemodialysis treatment and that assessment is what determines the patient as being either stable or unstable. Agreed with surveyor that the entire IDT should be involved in the comprehensive assessment and a new updated care plan should be completed deeming the patient as stable. 5. An interview was completed with the GFA (Group Facility administrator) on 1/14/2022 at 3:02 p.m. The GFA was present during the interview with the administrator provided above. The GFA indicated that for her home patients (the GFA is also the home manager for this facility and others in the area) the staff practice completing a comprehensive re-assessment including the entire IDT and then complete an updated care plan reflecting the patient as unstable. She was unaware that the ICHD were not following this same practice.			
V 0551 Bldg. 00	494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS The patient's vascular access must be monitored to prevent access failure, including monitoring of arteriovenous grafts and fistulae for symptoms of stenosis. Based on observation, record review, and interview, the facility failed to properly assess and monitor patient's Fistula or Grafts to prevent injury for 2 of 2 patients observed. (Patient 15 & 19) Findings include: 1. A policy last revised April of 2019 titled, "AV Fistula or Graft Cannulation" was provided by the	V 0551	The Facility Administrator or designee held a mandatory in-service(s) for all clinical teammates on Policy 1-04-01D AV Fistula or Graft Cannulation With JMS SYSLOC Mini Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose". Verification of attendance will be evidenced by a signature sheet. Teammates will be	02/12/2022

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	GFA on 01/13/2022 at 2:25 p.m. The document indicated but was not limited to; "Procedure 1. Have patient wash access site with appropriate antibacterial soap, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry ... 5. Perform inspection, auscultation, and palpation on entire length of access. Determine presence of bruit and thrill ..." 2. During an observation on 1/13/2022 at 10:47 a.m. CCHT K failed to auscultate patient 15's access site prior to cannulation.3. During an observation on 1/13/2022 at 10:36 a.m. Employee D failed to auscultate Patient 19's access site prior to cannulation. 4. An interview with the GFA and the administrator was completed on 1/13/2022 at 4:05 p.m. The administrator and GFA both agreed that staff should be auscultating the dialysis access prior to cannulation. The administrator indicated he was surprised that this was not being done.		instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Have patient wash access site with appropriate antibacterial soap, if able. If patient unable to wash access site, patient care teammate will clean access extremity with skin cleansing agent and pat dry. 2) Perform...auscultation...of the access. Determine presence of bruit and thrill. The Facility Administrator or designee will conduct observational audits of Fistula or Graft cannulation procedure for auscultation of the access for twenty five (25%) of AVF/AVGs daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the observational audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance 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.	