STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152645	A. BUILDING 00 B. WING	06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON DIALYSIS	9210 ROCKVILLE RD STE D INDIANAPOLIS, IN 46234

(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, for a Medicare participating End Stage Renal Disease Supplier. Dates of survey: 05-30, 05-31, 06-01, and 06-02-2023 Facility #: 012543 CCN: 152645 Stations: 12, including 1 isolation room. Census by Service Type: In Center Hemodialysis: 48 Home Peritoneal Dialysis: 26 Total Census: 74 At this Emergency Preparedness survey, Avon Dialysis, was found to have been in compliance with the requirements of Emergency Preparedness Requirements for Medicare participating providers and suppliers, including staffing, at 42 CFR 494.62. QR completed on 6/6/2023 by Area 3.	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: 05/30/23, 06/31/23. 06/01/23, 06/02/23	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaclynn Jackson	Facility Administrator	06/15/2023

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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	Census by Service Type: In Center Hemodialysis: 22 Home Peritoneal dialysis: 26 Total Census: 48 Isolation Room: 1 QR completed on 6/6/2023 by Area 3.			
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 the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, record review, and interview, the facility failed to ensure all employees followed infection control practice related to hand hygiene for 19 of 19 incorrect hand hygiene observations. (PCT 3, PCT 2 (3 times), PCT 1(3 times), RN 3, and RN 4) (Patient # 6, 22, 15, 20, 10, 29, 5, 1, 18 and 21) Findings include: 1. A review of facility policy 1-05-01, "Infection Control for Dialysis Facilities," last revised 04/23, indicated, but was not limited to, all teammates, physicians, and non-physicians will perform hand hygiene upon entering and exiting the patient treatment area, prior to gloving and immediately after removal of gloves, after contamination with blood or infectious material, after patient and dialysis delivery system contact, after interacting with wall boxes, between patients, and before touching clean areas. Alcohol-based hand rub	V 0113	The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene: upon entering and exiting the patient treatment area, prior to gloving and immediately after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, after interacting with wall boxes (i.e., plugging/unplugging acid/bicarb lines form dialysis	07/01/2023

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	may be substituted for handwashing unless hands are visibly contaminated with blood or body fluids. Disposable gloves will be worn when caring for a patient or touching the patient's equipment at the dialysis station. Gloves should be changed when soiled, when going from a dirty area/task to a clean area/task, when moving from a contaminated body site to a clean body site of the same patient, and after touching one patient or their dialysis delivery system and before arriving to care for or touch another patient's dialysis delivery system. 2. On 05/30/23 at 11:30 AM, PCT 3 completed hand hygiene, donned gloves, and began opening supplies on the chairside tray of occupied station 4. Without removing her gloves, PCT 3 walked to the central drawers and obtained supplies which she placed on the tray at Station #4. PCT 3 discarded her gloves, completed hand hygiene, donned new gloves, and proceeded with patient care. PCT 3 failed to remove her gloves and complete hand hygiene when moving from dirty to clean and after having direct patient contact. 3. On 05/30/23 at 1:25 PM, PCT (Patient Care Technician) 2 assisted Patient #6 to don a glove, then hold pressure to the AV (arterial venous) site after dialysis was discontinued. PCT 2 failed to offer/provide hand sanitizer before the patient donned the glove and after the patient discarded the glove. 4. On 05/31/23 at 2:48 PM, PCT 1 completed hand hygiene, donned clean gloves, pulled the rolling sharps container closer to Patient #34's chair, then discontinued both needles from the patient's AV site. PCT 1 failed to maintain infection control when going from clean to dirty and back.		machine, changing acid types, when exchanging a dialysis machine), between patients even if the contact is casual, before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. 2) Use of an alcohol-based hand rub may be substituted for handwashing. 3) Disposable gloves will be worn when caring for the patient or touching the patient's equipment at the dialysis station… 4) Gloves should be changed when: When soiled…When going from a “dirty” area or task to a “clean” area or task; When moving from a contaminated body site to a clean body site of the same patient; and, After touching one patient or their dialysis delivery system and before arriving to care for another patient or touch another patient’s dialysis delivery system. 5) Patients and caregivers will be encouraged to: Perform hand hygiene after treatment before leaving treatment area. The Facility Administrator or designee will conduct observational audits on each shift 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	

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	5. On 05/31/23 at 3:04 PM, PCT 1 completed hand hygiene, donned clean gloves, reinfused the circuit for Patient #22, picked the patient's bag up from the floor, folded the patient's blanket, adjusted the patient's oxygen mask, and had Patient #22 stand for the blood pressure check. After the patient was seated again, PCT 1 pulled her chair closer to the patient, assisted the patient to don a glove to hold pressure, and initiated discontinuation of dialysis. After bleeding stopped, PCT 1 discarded the patient's glove and escorted the patient to the scale. PCT 1 failed to follow infection control standards for hand hygiene when moving from clean to dirty to clean, failed to follow infection control protocol when discontinuing dialysis from an AV site, and failed to ensure the patient completed hand hygiene before and after gloving. 6. On 06/01/23 at 10:31 AM, PCT 1 donned gloves, silenced the circuit at Station #4, discarded her gloves, obtained supplies from the central drawers, took them to Station #11, donned clean gloves, and exited to the lobby to escort an incoming patient. PCT 1 failed to complete hand hygiene before and after changing gloves, when moving from clean to dirty, and prior to obtaining supplies when not wearing gloves. 7. On 06/01/23 at 11 AM, PCT 2 discarded her gloves after removing Patient #1's soiled CVC (Central Venous Catheter) dressing, applied a pump of hand sanitizer to her left palm, rubbed both palms together for 3 seconds, donned clean gloves, and performed the remainder of the dressing change. When finished, PCT 2 discarded her gloves, applied a pump of sanitizer to her left palm, rubbed her palms together for 3 sec, donned clean gloves, and began initiation of dialysis for Patient #1. PCT 2 failed to maintain infection		review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	

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	control standards for hand hygiene/gloving before and after patient contact, during a CVC dressing change, and when changing gloves. 8. On 06/02/23 at 9:55 AM, PCT 2 assisted Patient #15 to don a glove and hold pressure to the AV site. After bleeding stopped, Patient #15 discarded the glove, weighed, and exited the building. PCT 2 failed to ensure Patient #17 performed hand hygiene prior to donning and doffing gloves. 9. On 06/02/22 at 10:28 AM, RN 4 assisted Patient #20 to don a glove and hold pressure to the AV site. After bleeding stopped, RN 4 assisted the patient in removing the glove and escorted the patient to the scale. RN 4 failed to ensure Patient #20 completed hand hygiene before and after gloving. 11. On 06/02.23 at 11:45 AM, the Administrator indicated hand hygiene should be completed before and after all gloving, before handling packaged supplies, and when typing at the shared computer between stations. Gloves should be changed between patients, when moving from dirty to clean areas, and patients should complete hand hygiene before and after gloving to hold pressure to their site.12. During an observation during the facility flash tour on 05-30-2023 at 9:50 AM, observed a sign above the sink at the entrance of the treatment area that stated, "Please wash your hands and access." 13. During an observation on 05-30-2023 at 2:30 PM, Patient #10 was observed holding pressure to their right upper fistula site post dialysis with a left gloved hand. PCT 2 applied a new dressing to Patient #10's access site. Patient #10, removed their glove, gathered their belongings, and left the			

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	treatment area. Patient #10 was not offered any hand sanitizer or instructed to perform hand hygiene prior to leaving the treatment area. 14. During an observation on 05-31-2023 at 3:10 PM, RN 3 was observed at station 5, discontinuing Patient #26 dialysis treatment. The RN with gloved hands silenced the dialysate machine alarm, then entered data on the island keyboard, without removing their gloves and performing hand hygiene. The RN then proceeded to the nursing station island opened the drawer and obtained alcohol wipes without removing their gloves and performing hand hygiene. The RN then removed their gloves and completed hand hygiene after placing the alcohol pads on the barrier on the tray of the lounge chair. 15. During an observation on 06-01-2023 at 9:55 AM, Patient #29 was observed holding pressure to their right upper fistula site post dialysis with a left gloved hand. The Registered Nurse (RN), RN 1, assisted Patient #29, removed their glove, gathered their belongings, and left the treatment area. Patient #29 was not offered any hand sanitizer or instructed to perform hand hygiene prior to leaving the treatment area. 16. During an observation on 06-01-2023 at 10:00 AM, Patient #5, was observed entering the treatment area. RN 1 took Patient #5's temperature and instructed Patient #5 to proceeded to Station 10 for initiation of dialysis. RN 1 failed to offer hand sanitizer or instruct Patient #5 to perform hand hygiene before going to their chair. 17. During an observation on 06-01-2023 at 10:30 AM, Patient #1, was observed entering the treatment area. Patient #1 proceeded to the scale then to Station 8 for initiation of dialysis. The			

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	Patient Care Technician, PCT 3, failed to offer hand sanitizer or instruct Patient #5 to perform hand hygiene before going to their chair. 18. During an observation on 06-02-2023 at 9:55 AM, Patient #18, was observed entering the treatment area. Patient #18 proceeded to Station 2 for initiation of dialysis. PCT #3 failed to offer hand sanitizer or instruct Patient #18 to perform hand hygiene before going to their chair. 19. During an observation on 06-02-2023 at 10:02 AM, Patient #21 was observed holding pressure to their left lower arm access post dialysis with a right gloved hand. Patient #21, removed their glove, gathered their belongings, and left the treatment area. Patient #21 was not offered any hand sanitizer or instructed to perform hand hygiene prior to leaving the treatment area. 20. A review of the Personnel Record for RN 3, was completed on 06-01-2023 at 2:00 PM. RN 3's Personnel record contained a facility certificate titled, "Star Learning" that indicated RN 3 successfully completed the agency's Infection Control Program on 02-28-2023. During an interview on 06-01-2023 at 3:05 PM, the Area Clinical Team Lead, when queried regarding the patient washing their hands and access prior to initiation of dialysis, confirmed the patients were to be offered hand hygiene and wash their access upon entering the treatment area and after discontinuation of treatment. The Area Clinical Team Lead further indicated; gloves were to be removed and hand hygiene prior to getting into the supply drawers, gloves were not to be worn on the computer island keyboards, and hand hygiene and new gloves were to be donned after touching the dialysate machine.			

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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, record review, and interview, the facility failed to ensure all dialysis stations were cleaned and disinfected between patients, including but not limited to the surfaces of the dialysis machine, tubing, chair, counter, the blood pressure cuff, and shelf for 2 of 5 station cleaning observations. (PCT 6, RN 4) Findings include: 1. A review of facility policy 1-05-01, "Infection Control for Dialysis Facilities," last revised 04/23, indicated, but was not limited to, disinfection should be completed by using a wiping motion with friction. All surfaces should be visibly wet. Surfaces should be allowed to air dry. At the end of each treatment, the dialysis station will be cleaned and disinfected, including but not limited to all surfaces in contact with the patient or their belongings and frequently contacted by healthcare personnel, such as the control panel, top/front/sides of dialysis machine, touchscreens, and countertops. The wall box, drain, and water supply lines and prime container are considered part of the delivery system. Non-disposable items are to be disinfected after each patient use. The chair side cart, monitor, and keyboard are considered clean areas.	V 0122	The Facility Administrator or designee will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Disinfection should be completed by using a wiping motion with friction. 2) Sufficient disinfectant should be applied so that surfaces are visibly wet. 3) Surfaces should be allowed to air dry in order to provide sufficient disinfectant contact time. 4) At the end of each treatment, the dialysis station will be cleaned and disinfected. 5) Surfaces to disinfect include but are not necessarily limited to: all surfaces in contact with the patient or their belongings (e.g., dialysis chair, tray tables, blood	07/01/2023

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	2. On 05/31/23 at 3:21 PM, PCT (Patient Care Technician) 6 was observed cleaning Station #11 after Patient #14 had vacated the station. PCT 6 obtained 2 bleach wipes and cleaned the surface of the dialysis pump, then wiped the chair's center surfaces in a circular motion. PCT 6 failed to remove her gloves and perform hand hygiene after removing all bloodlines and disposable equipment, failed to clean the prime container inside and out, failed to visibly wet all areas of the machine, including the top, front, and side surfaces and dialysate hoses and connectors. PCT 6 failed to fully recline the chair and visibly wet all external front-facing and side-chair surfaces, including down sides of the seat cushion and tops of the trays, and failed to clean the TV. 3. On 06/01/23 at 10:07 AM, RN (Registered Nurse) 4 was observed cleaning Station #7, which had been vacated. RN 4 obtained bleach wipes and was observed wiping the center surfaces of the chair back and seat. RN 4 partially opened the chair sides and wiped the front surface of each chair side, then immediately closed the sides, and left the station. RN 4 failed to fully open the chair sides and clean exposed areas, failed to fully wet all external front-facing and side-chair surfaces, and failed to allow the chair to air dry before closing the sides. On 06/01/23 at 2:45 PM, the Administrator and Area Team Lead was queried about dialysis station cleaning. The Area Team Lead indicated the dialysis station cleaning was inclusive of the seat back, sides, machine/lines/hoses/sides/wall box using 1:100 bleach solution.		pressure cuffs) and frequently contacted by healthcare personnel (e.g., control panel; top, front and sides of dialysis machine; touchscreens; countertops). 6) The Wall box, Drain and Water supply lines are considered part of the dialysis delivery system. 7) Non-disposable items are to be disinfected after each patient use…8) The chair side cart, terminals mounted on the counter, monitor and keyboard are considered clean areas. The Facility Administrator or designee will conduct observational audits on each shift 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 the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	

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V 0146 Bldg. 00	494.30(c)(2) IC-CATHETERS:GENERAL (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html Based on observation, record review, and interview the facility failed to ensure all staff maintained aseptic technique while caring for central vascular accesses for 4 of 4 central venous catheter site care observations (Patient Care Technician (PCT) 3 (2 times) and PCT 2 (2 times)). Findings include: 1. A review of policy 1-04-02B, last revised 04/23, "Central Venous Catheter (CVC) with ClearGuard HD [Hemodialysis] Antimicrobial End Caps Procedure," indicated, but was not limited to, complete hand hygiene and don clean gloves,	V 0146	The Facility Administrator or designee will in-service all clinical teammates on Policy 1-04-02B “Central Venous Catheter (CVC) With CLEARGUARD HD Antimicrobial End Caps Procedure”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Perform hand hygiene per	07/01/2023

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	position patient so that clothing is away from the exit site, place a moisture proof barrier under catheter limbs, remove old dressing and discard. Remove gloves and discard, perform hand hygiene, don clean gloves. Hold catheter with non-dominant hand and clean the exit site with 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol swab for a minimum of 30 seconds using a back-and-forth pattern with gentle friction progressing from the insertion site to the periphery using both sides of the swab. Repeat if site is not free of exudates, using a new swab. Clean each CVC limb/cap with a new large alcohol prep pad, starting close to the exit site and finishing with the cap. 2. On 05/30/23 at 9:40 AM, PCT 3 was observed performing site care of the CVC for Patient #3. PCT 3 removed and discarded the old dressing, completed hand hygiene, and donned clean gloves, and cleaned the site using a 2% Chlorhexidine Gluconate/70%Isopropyl Alcohol swab. PCT 3 was observed wiping the swab randomly over the exposed area, moving back and forth from the left side to the right, over the entry site and down the catheter, and underneath the catheter. PCT 3 changed sides of the swab intermittently during cleaning and returned intermittently to areas already cleaned. PCT 3 was observed gently wiping the insertion point, then wiping the right side of the CVC area, wiping the left side, then returning to the insertion site and cleaning down the catheter again. PCT 3 failed to secure the catheter with her non-dominant hand, failed to clean each side by moving from the insertion site to the periphery, and failed to switch to a clean side of the swab when changing sides. 3. On 05/30/23 at 11:40 AM, PCT 3 was observed performing site care of the CVC for Patient #34.		procedure. 2) Put on PPE… 3) Verify patient's clothing is secured away from the exit site/work area. 4) Place the second moisture proof barrier under catheter limbs. 5) Remove old dressing and discard. 6) Remove gloves and discard. 7) Perform hand hygiene per procedure and re-glove. 8) Holding catheter with the nondominant hand and using aseptic technique, 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. If site is not free of exudates, repeat this step with new 2% Chlorhexidine Gluconate/70% Isopropyl Alcohol swab. 9) Clean each CVC limb/cap with a new LARGE alcohol prep pad, starting close to the exit site and finishing with the cap. The Facility Administrator or designee will conduct observational audits on each shift for CVC care daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be	

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	PCT 3 was observed wiping the swab randomly over the exposed area, moving back and forth from each side of the entry point, over the entry site and down the catheter, and underneath the catheter. PCT 3 changed sides of the swab intermittently during cleaning and intermittently recleaned areas previously cleaned. PCT 3 was observed wiping the insertion point then wiping the right side of the CVC area, wiping the left side, then returning to the insertion site and cleaning down the catheter again. PCT 3 failed to secure the catheter with her non-dominant hand, failed to clean each side by moving from the insertion site to the periphery, and failed to switch to a clean side of the swab when changing sides. 4. On 06/01/23 at 11:10 AM, PCT 2 was observed performing site care of the CVC for Patient #3. PCT 2 was observed wiping the swab randomly over the exposed area, moving back and forth and circular from the left side to the right, over the entry site and down the catheter, and underneath the catheter. PCT2 changed sides of the swab intermittently during cleaning and returned intermittently to areas already cleaned. PCT 2 failed to secure the catheter with her non-dominant hand, failed to clean each side by moving from the insertion site to the periphery, and failed to switch to a clean side of the swab when changing sides. 5. On 06/02/23 at 9:35 AM, PCT 2 was observed performing site care CVC for Patient #15. PCT 2 was observed wiping the swab randomly over the exposed area, moving back and forth and circular from the left side to the right, over the entry site and down the catheter, and underneath the catheter. PCT2 changed sides of the swab intermittently during cleaning and returned intermittently to areas already cleaned. PCT 2		verified monthly during the internal infection control audit. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	

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	152645	A. BUILDING 00 B. WING	06/02/2023

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	failed to secure the catheter with her non-dominant hand, failed to clean each side by moving from the insertion site to the periphery, and failed to switch to a clean side of the swab when changing sides. 6. On 06/02/23 at 11:45 AM, the Area Team Lead indicated CVC site care included cleaning the entry site and down the catheter, using a 2% Chlorhexidine Gluconate/70%Isopropyl Alcohol swab. Then, using a side-to-side motion and beginning at the entry point, move to the outside and from top to bottom. Repeat on the opposite side using the other side of the swab. The Area Team Lead indicated wiping randomly around the site did not meet standards of care for CVC site care.			
V 0190 Bldg. 00	494.40(a) SOFTENERS-AUTO REGENERATE/TIMERS/SALT LVL 5.2.4 Softeners: auto regen/timers/salt/salt level Prior to exhaustion, softeners should be restored; that is, new exchangeable sodium ions are placed on the resin by a process known as "regeneration," which involves exposure of the resin bed to a saturated sodium chloride solution. 5.2.4 Softeners Refer to RD62:2001, 4.3.10 Automatically regenerated water softeners: Automatically regenerated water softeners shall be fitted with a mechanism to prevent water containing the high concentrations of sodium chloride used during regeneration from entering the product water line during regeneration.			

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	The face of the timers used to control the regeneration cycle should be visible to the user. 6.2.4 Softeners Timers should be checked at the beginning of each day and should be interlocked with the RO system so that the RO is stopped when a softener regeneration cycle is initiated. The softener brine tank should be monitored daily to ensure that a saturated salt solution exists in the brine tank. Salt pellets should fill at least half the tank. Salt designated as rock salt should not be used for softener regeneration since it is not refined and typically contains sediments and other impurities that may damage O-rings and pistons and clog orifices in the softener control head. Based on observation, interview, and record review, the facility failed to accurately monitor and maintain the water softener equipment and allowed the brine tank to lack salt pellets to the manufacturer's required levels. This failure had the potential to negatively affect the health and well-being of all 48 in-center hemodialysis patients. Findings Include: 1. A review of a DaVita Incorporated policy, with a revision date of October 2021, titled, "Water Treatment Systems Minimum Component Requirement" was provided by the Facility Administrator (FA), on 06-01-2023, at 8:30 AM. The document indicated but was not limited to, " ...When water softeners are required, the maximum hardness of softened water produced will meet the Reverse Osmosis manufacturer's specifications	V 0190	The Facility Administrator or designee will in-service all clinical teammates on Policy 2-03-01 “Water Treatment System Minimum Component Requirement” and 2-04-01A “”Daily Log Explanation 3rd Doc ”Water Treatment Minimum Component System”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) When water softeners are required, the maximum hardness of softened water produced will meet the RO manufacturers’ specifications.	07/01/2023

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	...Facilities are required to establish specific procedures that verify and demonstrate functionality of all critical alarm monitoring for both remote and proximal devices ..." 2. A review a DaVita Incorporated document dated August 2008, titled "Daily Water Treatment Log explanation" was proved by the FA, on 06-01-2023 at 8:30 AM. The document indicated but was not limited to, " ...Salt Level Brine Tank? Tank at least half full Yes/No/Not Applicably. Brine Tank. At the start of each operation day, check the salt level in the brine tank. If the salt level is above half full in the brine tank enter "Y" (YES) to indicate level is appropriate. If "Y" is entered, no other action is required for that day. If the level is not half full, enter "N" (NO). Fill brine tank with salt to the appropriate level and record action taken on the daily log. If necessary, contact the Biomed Team for direction and assistance ..." 3. A review of the documents titled "Daily Water Log" dated 05-01-2023 through 05-31-2023, was provided by the FA on 06-01-2023, at 8:30 AM. The documents indicated in the section titled, "Salt Level in Brine Tank?" documented "No" on the dates of 05-05, 05-06, 05-07, 05-08, 05-10, 05-11, 05-12, 05-13, 05-14, 05-15, 05-16, 05-19, 05-22, 05-23, 05-24, 05-25, 05-26, 05-27, 05-28, 05-29, 05-30, and 05-31-2023. 4. During an observation during the facility flash tour on 05-30-2023 at 9:45 AM, observed the brine tank to be ¼ full, water covered the salt pellets approximately six inches. 5. During an interview on 05-30-2023 at 12:30 PM, the Biomed Manager, when queried regarding the brine tank level, confirmed the salt pellets should be above the water level but the water should still		2) Facilities are required to establish specific procedures that verify and demonstrate functionality of all critical alarm monitoring for both remote and proximal devices… 3) Scavenger Brine Tank Salt Level - Tank at least half full Y / N / NA - Brine Tank: Fill Scavenger brine tank with salt to the appropriate level and record action taken on the daily log. If necessary contact the Biomed Team for direction and assistance. The Facility Administrator or designee will audit the “Daily Water Log” and observe the salt pellet level in the brine tank daily x 2 weeks, then weekly x 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 will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	

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	be visible, and the tank should be half full. 6. During an observation on 05-31-2023 at 10:40 AM, observed the brine tank lid not closed, the salt pellets ¼ level of the tank level, and with approximated 6 inches of water (H2O) covering the salt pellets. A manufacture label adhered to the brine tank indicated, "Verify salt level is above H2O level in the Brine tank." 7. During an observation on 05-31-2023 at 10:40 AM, observed in the supply room a sign on the wall "Salt" above a plastic pallet that contained no salt. 8. During an interview on 05-31-2023 at 12:00 PM, the FA, indicated they were aware of the issue and the order of salt pellets was decreased by mistake and the facility was to receive a shipment today. The FA further confirmed that the salt pellets should cover the water in the brine tank.			
V 0407 Bldg. 00	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). Based on observation, and interview the faiclity staff failed to ensure that the patients' accesses were visable at all times. (Patient: 10, 4, 22, 26, 9 and 36.) Findings Include: 1. During an observation on 05-31-2023 at 9:15 AM, Patient #10 at Station 10 was fully covered with a gray blanket. The patient's access was not fully visible to the staff. The patient's access	V 0407	The Facility Administrator or designee will in-service all clinical teammates on Policy 1-03-08 “Pre-Intra-Post Data Collection, Monitoring and Nursing Assessment”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but	07/01/2023

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	remained covered until 9:40 AM. 2. On 05/31/23 at 10:31 AM, during the initial flash tour, Patient #4 was observed receiving dialysis while sleeping in a reclined chair. The patient's body was covered with a blanket and the dialysis site was not visible. 3. On 05/31/23 at 2:55 PM, Patient #22 was observed receiving dialysis while sleeping in a reclined chair. The patient's extremities, torso, and neck were covered with a blanket. The patient's dialysis site was not visible. 4. During an observation on 05-31-2023 at 3:20 PM, Patient #26 at Station 15 was fully covered with a white gown. The patient's access was not fully visible to the staff. 5. During an observation on 05-31-2023 at 3:20 PM, Patient #9 at Station 6 was fully covered with a green jacket. The patient's access was not fully visible to the staff. 6. On 06/01/23 at 9:53 AM, Patient # 36 was observed receiving dialysis while sleeping in a reclined chair. The patient was covered with a blanket from neck to feet. The patient's dialysis site was not visible. 7. On 06/01/2023 at 10:15 AM, Patient #36 remained covered with a blanket and the dialysis site was not visible. PCT 6 (Patient Care Technician) was present in the patient's room and failed to uncover the dialysis site before leaving the room. During an interview on 06-02-2023 at 12:00 PM, the Area Clinical Team Lead, confirmed that the patient's access were to be visible to staff at all		not limited to the following: 1) The vascular access site, blood line connections and the patient's face should be visible throughout the dialysis treatment. The Facility Administrator or designee will conduct observational audits on each shift 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 the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	

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	times.			
V 0506 Bldg. 00	494.80(a)(3) PA-IMMUNIZATION/MEDICATION HISTORY The patient's comprehensive assessment must include, but is not limited to, the following: Immunization history, and medication history. Based on record review and interview, the facility failed to ensure that a TB (tuberculosis) status was known and documented prior to admission to the facility in 1 of 2 new admission records reviewed, (Patient #1) and failed to ensure all patient records contained an accurate list of medications the patient takes at home, for 1 of 7 active patient records reviewed. (Patient #22) Findings Include: 1. A review of an agency policy, with a revision date of April 2018, titled, "Tuberculosis Infection Control Policy" was provided by the Facility Administrator (FA), on 05-31-2023, at 1:45 PM. The document indicated but was not limited to, "PURPOSE: To minimize the exposure of tuberculosis in the dialysis setting ... Permanent Admission New to Dialysis OR Permanent Admission from a Non-DaVita Facility is to provide the following documentation prior to first treatment ... Requirement #1: Negative TST (one step) completed within three (3) months prior to admission; or Requirement #2 Negative TST (two-step) completed 3 months prior to first treatment; or Requirement #4 Chest X-ray and documented ... Requirement #1 met- Administer a second TST (2nd step of two step TST) one (1) to three (3) weeks after the pre-admission TST was obtained or as soon as possible following	V 0506	The Facility Administrator or designee will in-service all clinical teammates on Policy 12-07-03 “Tuberculosis Infection Control Policy”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) PURPOSE: To minimize the exposure of tuberculosis in the dialysis setting. 2) Permanent Admission New to Dialysis OR Permanent Admission from a Non-DaVita Facility is to provide the following documentation prior to first treatment… 3) Requirement # 1: Negative TST (one-step) completed within three (3) months prior to admission; Requirement # 2: Negative TST (two-step) completed within three (3) months prior to first treatment;… Requirement # 4: CXR and documented… 4) Requirement # 1 met – Administer a second TST (2nd step of two-step TST) one (1) to	07/01/2023

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	admission ... " 2. A review of facility procedure 1-06-07A, "Home Medication Reconciliation Procedure," indicated, but was not limited to, home medication reconciliations should be completed monthly. During the medication reconciliation, the licensed nurse will review the home medications with the patient/caregiver and validate the list of medications the patient is taking by comparing it against another source, such as the hospital discharge summary. Additional considerations include, but are not limited to, reviewing the indications for the medication, and reviewing whether the medication is correct for the condition for which it was prescribed. 3. Review of the "Prescribers Digital Reference" indicated Naloxone is used for known or suspected opioid overdose and is administered nasally, intramuscularly, intravenously, or under the skin. Naloxone is not manufactured in oral form. 4. A review of the clinical record for Patient #1, admission date 04-27-2023, was completed on 06-05-31-2023 at 12:25 PM. The clinical record failed to evidence medical documentation of a negative Mantoux skin test result completed prior to admission or a chest x-ray report by a radiologist that indicated a clear, negative, normal, or unremarkable result. A review of a facility document titled, "TB Testing" indicated Patient #1's name, facility ID, and the Patient's medical record number. The document was blank. During an interview on 05-31-2023 at 1:55 PM, the FA, indicated Patient #1 was to have had their TB		three (3) weeks after the pre-admission TST was obtained or as soon as possible following admission…The Facility Administrator or designee will audit 100% of medical records for patients admitted during the previous three (3) months to verify that a Tuberculosis status was known and documented in the medical record prior to admission. Ongoing compliance will be verified with 10% of medical records audited, to include new admissions, monthly during the internal medical record audit. The Facility Administrator or designee will in-service all home dialysis teammates on Policy 1-06-07A “Home Medication Reconciliation Procedure”. Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Home medication reconciliations should be performed monthly per CMS Quality Improvement Program (QIP). 2) The licensed nurse will complete the home medication reconciliation with the patient/caregiver. 3) During the medication reconciliation, the licensed nurse will: Review the Home Medication	

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	over 2 weeks ago and it was being completed now. The FA further indicated they could not find documentation of Patient #1's TB. 5. A review of the Kardex for Patient #22, reconciled by RN 5 on 05/15/23, indicated a home medication of Naloxone (a medication used to treat narcotic/opioid overdose in an emergency via nasal, intramuscular, intravenous, or under the skin administration.) 12.5 mg (milligrams) by mouth every morning as needed. 6. A review of the hospital discharge summary home medication list for Patient #22, dated 12/09/22, indicated Naloxegol (a prescription medication taken orally to treat constipation caused by opioid use) 12.5 mg by mouth daily as needed for constipation. The medication list failed to evidence Naloxone was prescribed for Patient #22. 7. On 05/31/23 at 2:30 PM, the Administrator indicated the medication list on the Kardex for Patient #22 incorrectly listed Naloxone instead of Naloxegol, and the patient's medications were inaccurately reconciled on 05/15/23.		List with the patient/caregiver and validate the list of medications the patient is or is not taking by cross-referencing it against another source… hospital discharge summary. 4) Additional questions to ask and things to consider during the home medication reconciliation include: What are the indications for the medications?... Was the right medication prescribed?...The Facility Administrator or designee will audit the "Home Medication List" with 100% of home patients or caregivers in person or by phone to verify accuracy of the "Home Medication List" in compliance with facility policy. Ongoing compliance will be verified monthly. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary			

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	team must provide the necessary care and services to manage the patient's volume status; Based on record review and interview, the agency failed to ensure that an initial nursing comprehensive assessment was completed prior to the initiation of the first dialysis treatment for a new admission in 1 of 2 new admission records reviewed. (Patient #2) Findings Include: 1. A review of a DaVita Incorporated policy, with a revision date of October 2021, titled, "New Patient Pre-Treatment Evaluation" was provided by the Facility Administrator (FA), on 05-31-2023, at 3:00 PM. The document indicated but was not limited to, " ...A registered nurse (RN) as required by federal regulation will perform an initial pre-treatment evaluation of all peritoneal dialysis (PD) patient prior to the initiation of their first treatment/training at the facility ..." 2. A review of the clinical record for Patient #2, with the admission date of 05-09-2023, was completed on 05-31-2023 at 1:35 PM. The record contained a facility document titled, "New Patient Pre-Treatment Initial Nurse Assessment" dated 05-25-2023, and signed by RN 5, 17 days after Patient #2's initial treatment. During an interview on 05-31-2023 at 2:45 PM, the Registered Nurse (RN), RN 2, indicated they completed Patient #2's admission paperwork, and training on first treatment on 05-09-2023, and did not document the assessment.	V 0543	The Facility Administrator or designee will in-service all clinical teammates on Policy 5-02-28 "New Patient Pre-Treatment Evaluation" 12-07-03 "Tuberculosis Infection Control Policy". Verification of attendance will be evidenced by an in-service sign in sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) A registered nurse (RN) as required by federal regulation will perform an initial pretreatment evaluation of all peritoneal dialysis (PD) patients prior to the initiation of their first treatment/training at the facility. The Facility Administrator or designee will audit 100% of medical records for patients admitted to the facility during the previous three months to verify compliance with facility policy requiring a pre-treatment evaluation was performed prior to the first treatment. Ongoing compliance will be verified with ten percent (10%) of medical records, including new admissions, audited monthly during the internal medical record audit. The Facility Administrator will review audit results with the Medical Director during monthly Quality Assurance Performance	07/01/2023

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			Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with the Plan of Correction.	