STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152630	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PORTAGE DIALYSIS	5823 US HWY 6 PORTAGE, IN 46368

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 494.62 Survey dates: 01/21/2025, 01/22/2025, 01/23/2025, and 01/24/2025 Total Census: 58 At this Emergency Preparedness Survey, Portage Dialysis was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: 01/21/2025, 01/22/2025, 01/23/2025, and 01/24/2025 Census by Service Type: In Center Hemodialysis: 46 Home Hemodialysis: 4 Home Peritoneal Dialysis: 8 Total Census: 58 Isolation Room: 0 Waiver: no waiver required The abbreviations used in this survey report: RN for Registered Nurse and PCT for Patient Care Technician	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Kirkley	Facility Administrator	02/10/2025

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

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V 0112 Bldg. 00	QR 1/30/25 Area 2 494.30(a) IC-CDC MMWR 2001 Based on observation, and interview, the dialysis facility failed to ensure PCT 2 followed standard infection control precautions in 1 of 1 observations of supplies dropped on floor (Patient #17). Findings include: During an observation on 01/22/2025, beginning at 10:40 AM, PCT 2, at station #4, was accessing Patient #17 left arm arteriovenous fistula (AVF) (access for hemodialysis) [HD] [a process to filter the blood of a patient whose kidneys do not work normally]. During the observation, station #4 had medical supplies on a barrier on the side tray table of the chair. During the observation, a wrapped gauze package fell to the floor, PCT 2 picked up the gauze package and placed the gauze package on the barrier with other medical supplies that included but not limited to gauze packages, and the dropped gauze package touched other gauze packages on the barrier. PCT 2 then cannulated (inserted needles) the AVF with 2 lines and opened a gauze package and placed the gauze on the lower part of the AVF. During an interview on 01/22/2025, beginning at 11:00 AM, PCT 2 indicated the gauze that dropped on the floor was picked up and placed on the side tray table due to the gauze remained in the wrapper and it would be ok to use. During an interview on 01/22/2025, beginning at 4:30 PM, the Administrator indicated that medical supplies that are dropped on the floor should be	V 0112	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning 1/22/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) SUPPLIES - Anytime the integrity of a package with or without an expiration date is in question, i.e., torn, ripped, wet or contaminated, the package and its contents must be disposed of and not used. 2) Clean areas should be clearly separated from contaminated areas…the Facility Administrator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator or designee will review results of the audits with teammates during homeroom meetings and with the Medical	02/22/2025

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	placed in the garbage.		Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the dialysis facility failed to ensure PCT 3 and PCT 5 performed hand hygiene (hand sanitizing with an alcohol based antiseptic or hand washing) after glove removal, when moving between patients or stations, and during arteriovenous fistula [AVF](access for hemodialysis)[HD](a process to filter the blood of a patient whose kidneys do not work normally) care in 3 of 5 observations of PCT 5 and in 1 of 1 observations of PCT 3 AVF site care. Findings include: 1.A center for disease control internet webpage CDC.gov indicated hand hygiene should be performed immediately before touching a patient, after touching a patient or patient's surroundings,	V 0113	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” beginning 1/22/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) HAND HYGEINE - All teammates, Physicians and Non-Physician (NPP) will perform hand hygiene -… prior to gloving and immediately after removal of gloves… after patient and dialysis	02/22/2025

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	after contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. 2. During an observation on 01/22/2025, beginning at 9:45 AM, PCT 5, at station #7, was discontinuing the right arteriovenous fistula for Patient #13. During the observation, PCT 5 discontinued the 1st line of the AVF and placed gauze on the site, PCT 5 removed her gloves and applied new gloves without performing hand hygiene. 3. During an observation on 01/22/2025, beginning at 9:58 AM, PCT 5, at station #7, was discontinuing Patient #13 2nd line of the AVF. During the observation, PCT 5 removed Patient #13's 2nd AVF line, removed her gloves and applied new gloves without performing hand hygiene. 4. During an observation on 01/22/2025, beginning at 9:58 AM, PCT 5, at station #7, was cleaning the HD station, PCT 5 removed her gloves and applied new gloves without performing hand hygiene and entered station #6 and typed on the keyboard. 5. During an interview on 01/22/2025, beginning at 11:20 AM, PCT 5 indicated hand hygiene should be performed between patients and stations, and when gloves are changed. 6. During an observation on 01/22/2025, beginning at 11:37AM, PCT 3, at station #11, was accessing Patient #22's AVF for HD. During the observation, PCT 3 palpated the AVF site, cleaned and cannulated (needle insertion) the AVF site. PCT 3 failed to change gloves and perform hand hygiene		delivery system contact… between patients even if the contact is casual…The Facility Administrator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	

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	before the AVF site cleaning. During an interview on 01/22/25, beginning at 11:55AM, PCT 3 indicated that hand hygiene and donning clean gloves was not necessary after locating and palpating the cannulation site and applying antiseptic. PCT 3 indicated that hand hygiene and donning new gloves was to be performed prior to cannulation.			
V 0146 Bldg. 00	494.30(c)(2) IC-CATHETERS:GENERAL Based on observation, record review, and interview, the dialysis facility failed to ensure central venous catheter [CVC] (catheter into large vein) standard infection control precautions were implemented by PCT 2 and PCT 5 to prevent catheter related infections in 2 of 3 CVC initiations (Patient #14, Patient #18) and 1 of 3 CVC discontinuations observed (Patient #6). Findings include: 1. A revised policy dated 10/2024, titled, "Central Venous Catheter [CVC] .... Procedure" indicated a 15 second hub scrub of the CVC should be performed during the process of connecting or disconnecting from the blood lines. The policy indicated that each CVC limb/cap should be cleaned with an alcohol prep pad starting close to the exit site and finishing with the cap. 2. During an observation on 01/22/2025, beginning at 10:35 AM, PCT 2, at Station #1, was initiating hemodialysis [HD](process to filter the blood of a patient whose kidneys do not work normally) access of Patient #14's CVC. During the observation, PCT 2 cleaned the 1st hub (access site) with an alcohol pad for 4 seconds, cleaned	V 0146	The Facility Administrator or Registered Nurse will in-serviced 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 signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Perform a 15 second hub scrub of the CVC during the process of connecting or disconnecting from the blood lines, including line reversal, or if the patient is disconnected during treatment for any reason. 2) Using aseptic technique, remove each cap. One at a time, disinfect each CVC hub with a new alcohol prep pad. Scrub each CVC hub for 15 seconds including the sides, threads and end of hub thoroughly with friction making sure to remove	02/22/2025

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	the 2nd hub with an alcohol pad for 2 seconds and inserted syringes into the hubs. PCT 2 failed to clean the 1st or 2nd lines of the CVC prior to insertion of the syringes. 3. During an observation on 01/22/2025, beginning at 11:15 AM, PCT 5, at Station #7, was initiating HD access of Patient #18's CVC. During the observation, PCT 5 cleaned the 1st hub and 2nd hub with an alcohol pad for 10 seconds and inserted syringes into the hubs. PCT 5 failed to clean the 1st and 2nd lines of the CVC prior to inserting the syringes. 4. During an observation on 01/22/2025, beginning at 10:40 AM, PCT 5, at station #8, discontinued HD access of Patient #6's CVC. During the observation, PCT 5 cleaned the 1st and 2nd hubs for 5 seconds with an alcohol pad and applied the caps (hub covers). PCT 5 failed to clean the 1st and 2nd lines of the CVC prior to applying caps. 5. During an interview on 01/22/2025, beginning at 11:00 AM, PCT 5 indicated a CVC hub should be cleaned with an alcohol swab for 60 seconds and the lines should be cleaned prior to the insertion of the syringes. 6. During an interview on 01/22/2025, beginning at 4:30 PM, the Administrator indicated CVC hubs should be cleaned for 15 seconds, and the lines and threads should be cleaned.		any residue, for example blood. The Facility Administrator will conduct observational audits of CVC 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 the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0220 Bldg. 00	494.40(a) BACT CONTROL-SUPPLY LINE DISINFECTED Based on record review and interview, the dialysis facility failed to document weekly disinfection of the reverse osmosis [RO] system in 2 of 10 weeks	V 0220	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-06-01 “Water Treatment System	02/22/2025

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	of daily water logs reviewed (week of 11/24/2024, and week of 01/13/2025) and failed to perform chemical residual checks the day after the disinfection in 3 of 10 weeks of daily water logs reviewed (week of 12/22/2024, week of 01/06/2025, and week of 01/20/2025). Findings include: A revised policy, dated 10/2021, titled, "Water Treatment System Disinfection" indicated that the RO system was to be disinfected at least weekly, the distribution system was to be disinfected weekly, and that independent residual chemical testing was to be performed prior to the beginning of the daily activities on the first treatment day following a water treatment system or membrane chemical disinfection. A review of Daily Water Logs, received on 01/22/2025, for dates 11/18/2024 to 01/22/2025, indicated weekly disinfection of the reverse osmosis system were not documented for the week of 11/24/2024 and 01/13/2025. A review of Daily Water Logs, received on 01/22/2025, for dates 11/18/2024 to 01/22/2025, indicated on 12/23/2024, 01/07/2025 and 01/21/2025 the RO system was disinfected. A review of Daily Water Logs, received on 01/22/2025, for dates 11/18/2024 to 01/22/2025, indicated that follow up disinfection residual were not documented 12/24/24, 01/08/2025, and 01/22/25 prior to the start of daily activities. During an interview on 01/22/2025, beginning at 3:20 PM, the Facility Administrator [FA], indicated the Daily Water Logs did not have documentation the chemical disinfection of the reverse osmosis		Disinfection". Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Some hot water-disinfected direct feed systems utilize chemicals for the RO and hot water for the distribution system: The RO is disinfected at least weekly using peracetic acid (PAA) solution • The distribution system is disinfected at least weekly. 2) Facility teammates are to perform independent residual chemical testing prior to the beginning of the daily activities on the first treatment day following a water treatment system or membrane chemical disinfection at ALL locations listed below where applicable. The Facility Administrator will audit the "Daily Water Logs" daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review 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. The	

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	system was completed on 11/25/2024 and 01/14/2025. The FA indicated the Daily Water Logs did not have documentation the chemical residual test after disinfection were performed on 12/24/24, 01/08/2025, and 01/22/25.		Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0406 Bldg. 00	494.60(c)(3) PE-ACCOMMODATE PT PRIVACY Based on observation, and interview, the dialysis facility failed to ensure accommodations were made to provide for patient privacy when patients are examined or treatment was provided, and body exposure was required in 1 of 1 patients with a leg arteriovenous graft [AVG](access for hemodialysis) [HD] (a process to filter the blood of a patient whose kidneys do not work properly) (Patient #16). Findings include: 1. A Patient's Rights document signed and dated 04/11/2022, by Patient #16, indicated a patient was entitled to the right to privacy and confidentiality in all aspects of treatment, the dialysis facility would make accommodations to provide for patient privacy when the patient's examination would require body exposure, and the dialysis facility could use screens or curtains. 2. During an observation on 01/22/2025, beginning at 10:45 AM, RN 1 prepared Parsabiv (a	V 0406	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 2-01-07A “Patient’s Rights” beginning 1/23/25”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) YOUR RIGHTS AS A PATIENT: … The right to privacy and confidentiality in all aspects of treatment. The dialysis facility will make accommodations to provide for patient privacy when patients are examined or body exposure is required, for example privacy screens or curtains… The Registered Nurse will offer the patient a means to provide privacy to include a drape sheet or privacy	02/22/2025

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	medication given intravenously to lower parathyroid hormone, phosphorus and calcium levels) and entered station #12 with Patient #16 receiving HD. During the observation, Patient #16 was sitting in the HD chair with his/her pants pulled down to the knees and was wearing boxers (underwear) with his/her legs exposed and no covering/draping to cover Patient's legs or boxers. During the observation, RN 1 administered the Parsabiv through the AVG site, exited the station and went to a sink to wash her hands. During the observation, 12 HD patients were present on the observation floor. 3. During an interview on 01/22/2025, beginning at 10:45 AM, RN 1 indicated Patient did not request any covering, Patient would wear breakaway pants and the dialysis facility did have screens and blankets to cover the patient but were not in use. 4. During an interview on 01/24/2025, beginning at 12:25 PM, the Administrator indicated the facility's best practice [method generally accepted as standard] for HD leg access would include patients being asked to wear shorts or would drape patients to ensure the HD access was visible and protect patient's privacy.		screen. The Facility Administrator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for provision of privacy during procedures. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0407 Bldg. 00	494.60(c)(4) PE-HD PTS IN VIEW DURING TREATMENTS Based on observation and interview, the dialysis facility failed to ensure patients hemodialysis [HD] (a process to filter blood of a patient whose kidneys do not work normally) access sites were visible during HD treatment (Patient #16, Patient	V 0407	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-08-03 “Pre-Intra-Post Treatment Data Collection, Monitoring and	02/22/2025

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	#20). Findings include: 1. During an observation on 01/22/25, beginning at 9:52 AM, Patient #20, at station #15, was receiving HD and was observed to have a blanket covering his/her body, including his/her right chest central venous catheter [CVC] (catheter into large vein). 2. During an observation on 01/22/2005, beginning at 9:45 AM, Patient #16, at station #12, was receiving HD and was observed with his/her left thigh Arteriovenous Graft [AVG] (access for hemodialysis) covered by a blanket. 3. During an interview on 01/22/2025, beginning at 9:46 AM, PCT 1 indicated that patients and their access should be in view of staff at all times.		Nursing Assessment" starting on 1/22/2025. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) The vascular access site, blood line connections and the patient's face should be visible throughout the dialysis treatment. Patients will be educated on the importance of keeping the vascular access site, blood line connections, and face visible during treatment. Documentation of education will be documented in the medical record. The Facility Administrator will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for visibility of patient's access site, blood line connections, and face during treatment. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action	

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			plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0551 Bldg. 00	494.90(a)(5) POC-VA MONITOR/PREVENT FAILURE/STENOSIS Based on observation, record review, and interview, the dialysis facility failed to ensure PCT 2 auscultated (listened usually with a stethoscope) an arteriovenous fistula [AVF] (access for hemodialysis)[HD] [process to clean the blood of a patient whose kidneys do not work normally] for a bruit (swishing sound caused by blood flow through an artery) in 1 of 3 AVF cannulations observed. (Patient #17). Findings include: A revised policy dated 10/2024, titled, "Arteriovenous Fistula and Arteriovenous Graft [AVG] Vascular Access Care," indicated inspection of the AVF, AVG access would include presence/absence of a bruit. During an observation on 01/22/2025, beginning at 10:40 AM, PCT 2, at Station #4, cleaned Patient #17's left arm AVF and cannulated (inserted needles) the AVF. PCT 2 failed to auscultate the AVF for a bruit prior to cannulation. During an interview on 01/22/2025, beginning at 11:00 AM, PCT 2 indicated she did not auscultate	V 0551	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-04-01D “AV Fistula Or Graft Cannulation With JMS SYSLOC Mini Safety Fistula Needles (SNF) and Administration of Heparin Loading Dose”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1) Perform inspection, auscultation and palpation on entire length of access. 2) Determine presence of bruit and thrill. The Facility Administrator will conduct observational audits for monitoring of the patient’s access prior to cannulation daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during an internal	02/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152630	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PORTAGE DIALYSIS	5823 US HWY 6 PORTAGE, IN 46368

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	Patient #17's AVF prior to cannulation. During an interview on 01/22/2025, beginning at 4:30 PM, the Administrator indicated an AVF/AVG should be auscultated prior to cannulation.		audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	
V 0726 Bldg. 00	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE Based on observation, record review, and interview, the dialysis facility failed to ensure the accuracy of medical record documentation in 2 of 3 clinical records reviewed for observation documentation. (Patient #17, Patient #16). Findings include: 1. A revised policy dated October 2020, titled, "Vascular Access Monitoring and Surveillance," indicated the arteriovenous fistula [AVF] and arteriovenous graft [AVG] [dialysis access]	V 0726	The Facility Administrator or Registered Nurse will in-service all clinical teammates on Policy 1-04-11 “Vascular Access Monitoring And Surveillance” starting 1/22/25. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples with emphasis on, but not limited to the following: 1)	02/22/2025

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	findings and interventions would be documented in the patients' medical records. 2. A PCT Job Description dated 04/2023, indicated the PCT duties and responsibilities would include but not limited to data entry and maintaining of patients' charts. 3. A Treatment Details Report, dated 01/22/2025, for Patient #17 indicated Patient's AVF was assessed for continuous bruit (sound caused by blood flow through an artery) and thrill (vibration felt). During an observation on 01/22/2025, beginning at 10:40 AM, PCT 2, at Station #4, cleaned Patient #17's left arm AVF and cannulated (inserted needles) the AVF. PCT 2 failed to auscultate the AVF for a bruit prior to cannulation. During an interview on 01/22/2025, beginning at 11:00 AM, PCT 2 indicated she did not auscultate Patient #17's AVF prior to cannulation. 4. During an interview on 01/24/2025, beginning at 12:00 PM, the Administrator indicated PCT 2 should not have documented the AVF site was assessed for a bruit on 01/22/2025; and if a HD access was not visualized staff should not document access was visualized. 5. During an observation on 01/22/2005, beginning at 9:45 AM, Patient #16, at station #12, was receiving HD and his/her left thigh Arteriovenous Graft [AVG] (access for hemodialysis) was covered by a blanket. At 10:09 AM, PCT 1 removed the blanket from Patient 's left thigh.		Results of the inspection are documented on the treatment log. 2) Data from the clinical assessment, monitoring and dialysis adequacy measurements should be collected, trended and maintained for each patient's access…The Facility Administrator will audit twenty-five percent (25%) of treatment detail reports will be audited daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports audited monthly x 3 months during the internal medical record audit. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review 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. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of	

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	A Treatment Sheet, dated 01/22/2025, indicated Patient #16 's AVG was visible to staff at 9:45 AM and 10:00 AM.		correction.	