STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152564	A. BUILDING 00 B. WING	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST CHICAGO DIALYSIS CENTER	4016 E MAIN STREET EAST CHICAGO, IN 46312

(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 State Department of Health in accordance with 42 CFR 494.62 Survey Dates: 01/09/2025, 01/10/2025, and 01/13/2025 Total Census: 75 At this Emergency Preparedness Survey, East Chicago Dialysis Center 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 of an ESRD provider. Survey Dates: 01/09/2025, 01/10/2025, and 01/13/2025 Census by Service Type: In Center Hemodialysis: 75 Home Peritoneal Dialysis: Not offered Home Hemodialysis: Not offered Total Census: 75 1 Isolation Room	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shauna Valdivia	Director of Operations	02/14/2025

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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	The abbreviations used in this survey report: RN for registered nurse and PCT for patient care technician. QR: A 1 January 19, 2025			
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the dialysis facility failed to ensure PCT 2 and PCT 3 performed hand hygiene, hand sanitizing with an alcohol based antiseptic or hand washing, after glove removal, between patients and when moving between patients' hemodialysis [HD] (a process to filter the blood of a patient whose kidneys do not work normally) stations durin 1 of 5 observations conducted of PCT 2 and 1 of 1 observations of PCT 3. Findings include: 1. A policy dated 11/06/2023, titled, "Hand Hygiene," indicated an alcohol-based hand rub or hand washing with an antimicrobial soap and water should be performed before and after direct contact with patients, immediately after removing gloves, and after contact with inanimate objects near a patient. 2. During an observation on 01/09/2025, beginning at 9:42 AM, PCT 2 was typing on the computer keyboard at station #16, PCT 2 removed her gloves, and applied new gloves; without completing hand hygiene she entered station #14 and obtained Patient #16's blood pressure and placed a barrier under Patient's right arm. Without hand hygiene PCT 2 entered station #13, she	V 0113	By 01/30/25 Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Hand Hygiene Emphasis placed on: Hands will be decontaminated using alcohol-based hand rub (without waving hands to dry, due to potential air borne contaminants) or by washing hands with antimicrobial soap and water: *Before and after direct contact with patients* Entering and leaving the treatment area Before performing any invasive procedure such as vascular access cannulation or administration of parenteral medications Immediately after removing gloves. After contact with body fluids or excretion, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled.	02/11/2025

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	picked up Patient #15's coat and escorted Patient #15 to the scale, then PCT 2 opened the door to the foyer, and Patient #15 left. PCT 2 then returned to station #13, typed on the computer keyboard with the same gloves, then removed their gloves and applied new gloves without performing hand hygiene. 3. During an observation on 01/09/2025, beginning at 9:42 AM, PCT 2 was at station #14 with Patient #16, she removed 1 line from Patient's arteriovenous fistula [AVF](access for HD), PCT 2 removed gloves and gown, applied new gown and gloves without performing hand hygiene. 4. During an observation, on 01/09/2025, beginning at 9:42 AM, PCT 2 was at station #13 cleaning the station chair and then entered station #14 with the same gloves to clean the front of the computer while Patient #16 remained at station #14, PCT 2 then removed her gloves, applied new gloves without performing hand hygiene. 5. During an observation on 01/09/2025, beginning at 10:15 AM, PCT 2 went to station #15 with Patient #17, PCT 2 removed her gloves, applied new gloves without performing hand hygiene and typed on station #15's computer keyboard, PCT 2 then entered station #14 with the same gloves and touched the HD supplies on the tray side table, PCT 2 removed her gloves without performing hand hygiene and entered station #13 to set up the intravenous saline tubing, PCT 2 then removed her gloves, and applied new gloves without performing hand hygiene, PCT 2 then entered station #14 with Patient #16 and removed the 2nd line of the AVF, PCT 2 then removed her gloves and applied new glove without performing hand hygiene.		After contact with inanimate objects near the patient When moving from a contaminated body site to a clean body site of the same patient After contact with the dialysis wall box, concentrate, drain, or water lines. After contact with other objects within the patient station or treatment space Washing Hands with Soap and Water - *Duration of the entire procedure: 40-60 seconds* Decontaminating Hands with Alcohol Based Hand rubs - Duration of the entire procedure: 20-30 seconds. Apply alcohol-based hand rub to the palm of one hand using the amount recommended by the product manufacturer. An adequate amount of product must be used for maximum effectiveness. Rub hands together covering all surfaces of the hands and fingers, *until hands are dry*. Allowing alcohol to dry completely allows adequate contact time to kill germs, allows alcohol to evaporate and prevents risk of igniting flames due to alcohol's flammable properties. Importance of donning gloves on both hands when touching any part of the dialysis machine or equipment at the dialysis machine, to include but not limited to answering alarms or	

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	6. During an observation on 01/09/2025, beginning at 10:25 AM, PCT 2 entered station #17 with Patient #18, due to the AVF removal site was bleeding, and touched Patient's AVF site and then entered Station #14 with Patient #16 wearing the same gloves from station #17 and touched the supplies Patient #16's chair tray. During the observation, the Clinical Manager spoke to PCT 2, PCT 2 then removed her gloves and applied new gloves without performing hand hygiene, PCT 2 entered station #14 with Patient #16 and applied a new gauze to the AVF site, a red substance was visible on the barrier under the AVF and the barrier was disposed of in the garbage, PCT 2 removed her gloves, applied new gloves without performing hand hygiene and returned to station #14. 7. During an observation on 01/09/2025, beginning at 10:30 AM, PCT 2 was at station #16 with Patient #31, disconnected Patient's left central venous catheter [CVC](catheter into large vein), PCT 2 removed her gloves, applied new gloves without performing hand hygiene and then escorted Patient #31 to the scale, PCT 2 touched the scale buttons with gloves on, returned to station #16 and touched the computer keyboard without changing gloves. 8. During an observation on 01/09/2025, beginning at 11:00 AM, PCT 3 cleaned station #18's HD machine and bucket was emptied into the dirty sink, PCT 3 then removed her gloves, applied new gloves without performing hand hygiene, entered station #18 and cleaned the blood pressure cuff and chair. 9. During an observation on 01/09/2025, beginning at 12:45 PM, PCT 2 was at station #14 typing on the keyboard with gloves on, wearing		entering data into the dialysis machine computer screen. Never wear only one glove or wrap a finger with a glove to perform any dialysis task. Perform hand hygiene prior to accessing supplies, handling vials and IV solutions and preparing or administering medications. Effective 02/03/2025, the Clinical Manager or Charge Nurse will conduct infection control audits weekly, 3 times per week, with alternating shifts with focus on ensuring staff perform hand hygiene per policy, as required, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 2 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status	

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	the same gloves PCT 2 then went to the scale to weigh Patient #17, PCT 2 then returned to station #15 with Patient #17 and typed on the keyboard without changing gloves. 10. During an interview on 01/09/2025, beginning at 10:45 AM, PCT 2 indicated hands should be cleaned with hand sanitizer between each patient and station and after each glove change.		of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
V 0126 Bldg. 00	494.30(a)(1)(i) IC-HBV-VACCINATE PTS/STAFF Based on record review and interview, the dialysis facility failed to ensure 27% of qualified patients susceptible to Hepatitis B (liver infection) were offered the Hepatitis B vaccine in 1 of 1 agency (Patient #1, 5, 6, 9, 18, 32, and 35). Findings include: 1. A policy dated 02/07/2022, titled, "Patient Vaccination for Hepatitis B," indicated a patient	V 0126	By 01/30/25 Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Patient Vaccination for Hepatitis B Emphasis placed on: The Hepatitis B vaccine	02/11/2025

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	with a Hepatitis B anti-HB (antibody to Hepatitis B) level less than 10 (susceptible to Hepatitis B) and had a reported previous vaccination the patient should be vaccinated, and if a patient had a previous Hepatitis B anti-HB level greater than or equal to 10 and the level falls below 10 the physician should be notified to discuss administration of a Hepatitis B booster dose. 2. An Infection Surveillance Platform, dated 01/13/2025, indicated 63% of patients were immune to Hepatitis B, 33% of patients were susceptible to Hepatitis B, and 1% of susceptible patients had a valid excuse. 3. An undated Patient Detail Report for Hepatitis B, received on 01/10/2025, indicated of the 26 patients that were susceptible to Hepatitis B, 42% of patients were in the process of receiving the Hepatitis B vaccine series, 12% patients refused, 4% of patients did not qualify due to a diagnosis of acute kidney injury, 8% of patients were non-responders to the vaccine, 8% patients had the Hepatitis B antibody checked after 12/22/2024, and 27% of patients that qualified for the Hepatitis B vaccine were not offered the Hepatitis B vaccine. 4. An undated Patient Detail Report for Hepatitis B indicated Patient #1 had a Hepatitis B surface antibody result (anti-HB) less than 10 on 10/24/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 5. An undated Patient Detail Report for Hepatitis B indicated Patient #5 had a Hepatitis B anti-HB less than 10 on 10/22/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine.		shall be offered to all susceptible patients including peritoneal and home hemodialysis patients. The current vaccine information statement (VIShttp://www.immunize.org/vis/) will be given to patients prior to administration of each dose of vaccine for hepatitis B. Patients shall sign a vaccination consent/declination form. The hepatitis B vaccine should be given intramuscularly in the deltoid muscle only. A protective antibody response is 10 or more milliinternational units (mIU) per milliliter (anti-HBs ³ 10mIU/mL). Test patients who have received hepatitis B vaccine for anti-HBs (hepatitis B surface antibody) 2 months after the final dose of vaccine per physician order. Protection against hepatitis B is not maintained when antibody titers fall below 10 mIU/mL. Patients who do not respond to the primary vaccine series should be revaccinated with one additional vaccine series and retested for response 2 months after the final dose of vaccine. The anti-HBs level falls below 10 mIU/mL, in a patient whose anti-HBs was greater than or equal to 10 mIU/mL after the vaccination series If patient is sitting in buffer zone, remove patient from buffer zone. Discuss and obtain order for	

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	6. An undated Patient Detail Report for Hepatitis B indicated Patient #6 had a Hepatitis B anti-HB less than 10 on 10/17/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 7. An undated Patient Detail Report for Hepatitis B indicated Patient #9 had a Hepatitis B anti-HB less than 10 on 05/14/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 8. An undated Patient Detail Report for Hepatitis B indicated Patient #18 had a Hepatitis B anti-HB less than 10 on 05/14/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 9. An undated Patient Detail Report for Hepatitis B indicated Patient #32 had a Hepatitis B anti-HB less than 10 on 11/22/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 10. An undated Patient Detail Report for Hepatitis B indicated Patient #34 had a Hepatitis B anti-HB less than 10 on 05/13/2024 and failed to evidence a reason Patient was not offered a Hepatitis B vaccine. 11. During an interview on 01/10/2025, the Clinical Manager (Administration Person 2) indicated Patient #1, Patient #9, Patient #32, and Patient #34 should have been offered the Hepatitis B vaccine and was not offered the vaccine, Patient #5 should have been offered the Hepatitis B vaccine and was not offered the vaccine due to Patient could not consent for it by themselves and the dialysis facility would need to reach out to a family member to consent due to Patient resided in		administration of a booster dose with physician. A booster is a single dose of hepatitis B vaccine. Test for anti-HBs 2 months after the booster dose. Effective 01/30/2025, the Clinical Manager will review 100% of all patients' Hepatitis B blood results. Any patient identified as susceptible for Hepatitis B will be offered vaccine or declination will be obtained. Effective 02/03/2025, the Clinical Manager or Charge Nurse will perform monthly Hepatitis B audits with a focus on ensuring all new patients are offered the Hepatitis B Vaccine, or a signed declination will be obtained and available in the patient's medical record per policy, as required, utilizing Hepatitis B Monitoring Tool for 3 months and then an additional 3 months or until 100% is achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit	

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	a skilled nursing facility, Patient #6 should have been offered the Hepatitis B vaccine and was not offered the vaccine due to Patient was noncompliant with treatments, and Patient #18 should have been offered the Hepatitis B vaccine and was not offered the vaccine due to was a Spanish speaking patient and would need to be offered Patient Hepatitis B information in Spanish.		results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
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 to prevent catheter related	V 0146	By01/30/25 Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Initiation of Treatment	02/11/2025

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	infections in 1 of 2 CVC initiations observed (Patient #1). Findings include: A Center for Disease Control website CDC.gov, titled, "Hemodialysis Central Venous Catheter," indicated a CVC should be disinfected with an antiseptic pad for each hub(end of catheter access), the threads (sides of the hub) should be scrubbed thoroughly to remove any residue, and an antiseptic pad should be used to clean the limbs (catheter lines) at least several centimeters towards the body. A policy dated 05/06/2024, titled, "Initiation of Treatment Using a Central Venous Catheter (CVC) ...." indicated catheter threads and ends of the hub must be scrubbed with 70% alcohol for 10-15 seconds any time caps are removed, use a 70% alcohol pad to remove any exude on the limbs, and use an alcohol pad to clean from the hub at least several centimeters towards the body of the catheter and then attach a sterile syringe. During an observation on 01/09/2025, beginning at 11:45 AM, PCT 2 was observed at station #14 initiating access of Patient #1's CVC. During the observation, PCT 2 removed the CVC's hub caps on 2 lines and cleaned the 1st hub with an alcohol pad for 5 seconds; then she cleaned the 2nd hub with an alcohol pad for 3 seconds and inserted syringes into the hub. PCT 2 failed to clean the 1st or 2nd lines of the CVC, prior to insertion of the syringes, per policy and infection prevention standards of care. During an interview on 01/09/2025, beginning at 12:50 PM, PCT 2 indicated CVC hubs should be cleaned with an alcohol pad for 1 minute prior to		Using a Central Venous Catheter (CVC) and Optiflux Single Use Ebeam Dialyzer Emphasis placed on: Follow the steps below to disinfect the catheter connections: Threads and end of the luer lock (hub) must be scrubbed with 70% sterile alcohol pad (or other antiseptic such as chlorhexidine, povidone if required by the hospital) for 10-15 seconds and any time caps are removed, or bloodlines are disconnected (i.e. end of treatment or treatment interruption) to reduce risk of contamination. Check to make sure catheter clamps are closed. Remove cap from clamped arterial limb Using a sterile alcohol pad (or other antiseptic such as chlorhexidine, povidone) scrub the sides (threads) and end of the hub thoroughly with friction, making sure to remove any residue (e.g., blood). Do not place uncapped catheter limbs on under pad to prevent contamination Using the same sterile alcohol pad (or other antiseptic such as chlorhexidine, povidone if required by the hospital) applying friction to remove any blood or residue, move from the hub at least several centimeters towards the body of the catheter. (Steps 3 and 4 should take 10-15 seconds.) Hold the limb while allowing	

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	insertion of syringes. During an interview on 01/10/2025, beginning at 3:00 PM, the Clinical Manager (Administration Person 2), indicated CVC site care would include cleaning the hub for 30 seconds with alcohol and the threads of the CVC should be cleaned.		the antiseptic to dry Attach a sterile empty 10 mL syringe to limit exposure to air. Repeat stes 1-6 for venous catheter limb Effective 02/03/2025, the Clinical Manager or Charge Nurse will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring with CVC and removing the catheter hubs staff will scrub with alcohol pad for 10-15 seconds for all procedures that require accessing the catheter per policy, as required, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 2 weeks or until 100% compliance achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.	

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			The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
V 0511 Bldg. 00	494.80(a)(8) PA-DIALYSIS ACCESS TYPE & MAINTENANCE			

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	Based on observation, record review, and interview, the dialysis facility failed to ensure cannulations (insertion of needles) of arteriovenous fistula [AVF] (access for hemodialysis) [a process to filter the blood of a patient whose kidneys do not work normally] and arteriovenous graft [AVG] (access for hemodialysis) were completed by PCT 1 and PCT 2 to prevent AVF/AVG site infections in 4 of 4 AVF/AVG cannulations observed (Patient #8, #20, #23, and #30). Findings include: 1. A Center for Disease Control website CDC.gov titled, "AV Fistula, Graft Cannulation Observations," indicated the AVF/AVG site should not be contacted after antiseptic was applied. 2. During an observation on 01/09/2025, beginning at 11:00 AM, PCT 2 was cannulating Patient #20's right upper arm AVF at station #13, PCT 2 cleansed the AVF site with an alcohol prep pad and cannulated with the first line; she then recleaned with an alcohol prep pad, repalpated (touched) the site, and then cannulated the second line without recleaning the access site. 3. During an observation on 01/09/2025 beginning at 12:20 PM, PCT 2 was cannulating Patient #23's left arm AVF at station #16; PCT 2 cleaned the AVF site with an alcohol prep pad and therepalpated the insertion site prior to cannulating the first line. PCT 2 then repalpated the insertion site, prior to cannulating the second line. 4. During an interview on 01/09/2025, beginning at	V 0511	By 01/30/2025, the Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Access Assessment and Cannulation Emphasis placed on: Disinfect cannulation site as follows using any of the disinfectants below: 70% isopropyl alcohol pad: Using gentle friction, clean the access site beginning in the center and continuing outward 2 inches in a concentric circle for 30 seconds and allow to dry before cannulating. Povidone Iodine pad: Work outward 2 inches in a concentric circle using gentle friction for a minimum 30 seconds and allow to dry for 3 minutes before cannulating. 2% Chlorhexidine and 70% alcohol: Work outward 2 inches in a concentric circle using gentle back and forth friction to clean for a minimum 30 seconds and allow to dry before cannulating. Perform skin antisepsis on one site at a time, allow to dry and then cannulate. Do not touch cannulation sites after skin disinfection. Note: This method minimizes the risk of contaminating the second site while cannulating the	02/11/2025

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	152564	A. BUILDING 00 B. WING	01/13/2025

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	12:50 PM, PCT 2 indicated an AVF/AVG site should not be repalpated after the insertion site was cleansed with alcohol. 5. During an observation on 01/09/2025, beginning at 10:53 a.m., observed PCT 1 cannulating Patient #8's AVF at station #8; PCT 1 cleaned the AVF site with an alcohol prep pad and repalpated the insertion site, prior to cannulating the first line without recleaning the insertion site. PCT 1 then repalpated the insertion site prior to cannulating the second line without recleasing the insertion site before cannulation. 6. During an observation on 01/09/2025, beginning at 12:30 p.m., PCT 1 was cannulating Patient #30's AVF at station #6. PCT 1 cleaned the AVF site with an alcohol prep pad and then repalpated the insertion site, prior to cannulating the first line. PCT 1 then repalpated the insertion site prior to cannulating the second line. PCT 1 did not reclean the insertion sites prior to cannulation.		first site. Observe cannulation site for any reaction to antimicrobial solution. Effective 02/03/2025, the Clinical Manager or Charge Nurse will conduct infection control audits 3 times per week, with alternating shifts with focus on ensuring with cannulation of site i.e. AVF/AVG staff will perform disinfect with alcohol pad for 30 seconds, allow site to dry, the perform cannulation per policy, as required, utilizing Infection Control Monitoring Tool for 2 weeks and then 2 times per week for an additional 2 weeks or until 100% compliance achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly.	

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			The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
V 0543 Bldg. 00	494.90(a)(1) POC-MANAGE VOLUME STATUS	V 0543	By 01/30/2025, the Clinical	02/11/2025

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	Based on observation, record review, and interview, the dialysis facility failed to ensure PCT 6 administered the correct hemodialysis [HD] (a process to clean the blood of a patient whose kidneys do not work normally) prescription in 1of 5 active in-center hemodialysis prescriptions reviewed with the Clinical Manager, while on the observation floor (Patient #24). Findings include: A job description dated 07/12/2022, titled, "PCT 1," indicated the PCT was responsible for the setup and operation of the HD machine. The job description indicated the PCT responsibilities would include initiate dialysis treatment according to the prescribed orders. During an observation on 01/09/2025, beginning at 11:22 AM, Patient #24, at Station #9 was receiving HD dialysate 2.0 K (potassium) 2.5 Ca (calcium). The elctronic medical record revealed the most recent prescription was dated 12/04/2024, Patient #24's prescription for dialysate was 3.0 K 2.5 Ca. A Treatment Sheet dated 01/10/2025, indicated PCT 6 performed the machine set up and the HD was initiated by PCT 6. During an interview on 01/09/2025, beginning at 11:22 AM, the Clinical Manager (Administration Person 2) indicated Patient was receiving the incorrect HD dialysate. During an interview on 01/09/2025, beginning at 11:22 AM, PCT 6 indicated the HD prescription dialysate set up was incorrect and Patient received the incorrect dialysate bath.		Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Nursing Supervision and Delegation Emphasis placed on: The registered nurse must evaluate each patient preferably within an hour of treatment initiation to: Confirm identify Review the patient's condition. Review accuracy and completeness of treatment and patient data Review patient treatment prescription and equipment parameters to verify correct settings, and if dialysis prescription is being followed. Confirm that the correct vascular access is being used, and that the access is visible. Observe patient's response to treatment Verify machine safety checks have been completed. Talk to the patient to elicit information such as changes in condition, response to treatment, new injuries, information/education needs or complaints, satisfaction with care. Effective 02/03/2025, the Clinical Manager or Charge Nurse will conduct Floor Observation audits 3 times per week, with alternating shifts with focus on ensuring all	

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			patient treatment prescriptions are being followed per policy, as required, utilizing Specific Plan of Correction Monitoring Tool for 2 weeks and then 2 times per week for an additional 2 weeks or until 100% compliance achieved. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause	

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			analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	
V 0726 Bldg. 00	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE Based on record review and interview, the dialysis facility failed to ensure the treatment records were complete and accurate in 4 of 8 active in-center hemodialysis [HD](a process to filter the blood of a patient whose kidneys do not work normally) patients clinical records reviewed (Patient #4, 5, 7, 8). Findings include: 1. A PCT job description dated, 07/12/2022, indicated the responsibilities for a PCT would include but not limited to initiating HD according to the prescribed orders including the blood flow	V 0726	By 01/30/2025, the Clinical Manager will hold a staff meeting and reinforce the expectations and responsibilities of the facility staff on policy and procedure: Patient Assessment and Monitoring Emphasis placed on: Document machine parameters and safety checks every 30 or more often as needed but not to exceed 45 minutes or per state regulations.	02/11/2025

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	rate [BFR] and DFR [dialysate flow rate], and record accurate documentation of information related to the patients' treatment on the hemodialysis treatment sheet. 2. A Treatment Sheet, dated 01/09/2025, indicated Patient #4's HD treatment began at 1:24 PM; the record failed to evidence the BFR and DFR were documented from 3:00 PM until the end of treatment at 4:33 PM. 3. A Treatment Sheet, dated 01/07/2025, indicated Patient #5's HD treatment was initiated at 12:53 PM; the record failed to evidence the BFR and DFR were documented from 1:36 PM until the end of treatment at 3:57 PM. 4. A Treatment Sheet dated 01/04/2025, indicated Patient #7's HD treatment was initiated at 7:08 AM; the record failed to evidence the BFR and DFR were documented from 9:32 AM until the end of treatment at 11:06 AM. 5. A Treatment Sheet dated 01/09/2025, indicated Patient #8's HD treatment was initiated at 11:13 AM; the record failed to evidence the BFR and DFR were documented from 11:13 AM until the end of treatment at 2:37 PM. 6. During an interview on 01/13/2025, beginning at 11:40 AM, the Clinical Manager (Administration Person 2) indicated that the DFR and BFR should be documented by PCT's manually if the HD machine fails to sync with the documentation system. The Clinical Manager indicated the BFR and DFR for Patient #4, Patient #5, Patient #7, and Patient #8 were not documented correctly and should have been documented by the PCT.		Check machine settings and measurements: Check prescribed blood flow is being achieved or reason is documented in medical record if unable to meet prescribed blood flow. Check dialysate flow rate setting is correct, and the prescribed flow is being delivered. Effective 02/03/2025, Clinical Manager or Charge Nurse will conduct 10 treatment sheets daily, alternating shifts, with focus on ensuring patient dialysis prescription orders are verified and adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis utilizing Treatment Sheet Audit Tool for 2 weeks and then will complete weekly treatment audits on 10% of completed treatments for an additional 2 weeks. The Governing Body will determine on-going frequency of the audits based on compliance. Once compliance sustained monitoring will be done through the Clinic Audit Checklist per QAI calendar. The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Clinical Manager is responsible to review, analyze and trend all data and Monitor/Audit	

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			results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible for providing oversight, reviewing findings, and taking actions as appropriate. The root cause analysis process is utilized to develop the Plan of Correction. The Plan of correction is reviewed in QAI monthly. The Governing Body is responsible for providing oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues. The QAI and Governing Body minutes, education and monitoring documentation are available for review at the clinic.	

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