STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152619	A. BUILDING 00 B. WING	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORYDON DIALYSIS CENTER	1937 OLD SR 135N CORYDON, IN 47112

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62. Survey Dates: February 20th, 21st, and 22nd of 2023 Census: In-Center Hemodialysis 24 At this Emergency Preparedness Survey, Corydon Dialysis Center, was found in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62. QR Completed 2/24/2023 A4	E 0000		
V 0000 Bldg. 00	This visit was for a Federal Core ESRD Recertification Survey. Survey Dates: February 20th, 21st, and 22nd of 2023 Census: In-Center Hemodialysis 24	V 0000		
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Rose	Facility Administrator	03/10/2023

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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	I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on record review, observation, and interview the facility failed to ensure that appropriate infection control measures were demonstrated by staff to prevent the possible transmission of infection of CVC's (central venous catheters) in 1 of 2 CVC initiations and 1 of 2 discontinuations of CVCs observed. (Patient 1) Findings Include: 1. A policy titled, "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps and	V 0147	The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 02/20/23. Surveyor observations were reviewed. Education included but was not limited to review of video: CVC Treatment Initiation Utilizing ClearGuard End Caps 19-313859469, review of Quick Care Reminder Card: CVC Care Using ClearGuard HD Antimicrobial Barrier Caps, Ver.	03/28/2023

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	Tegaderm CHG Dressing Procedure" dated October 2022 was provided by the MCS (manager of clinical services) on 2/20/2023 at 3:36 p.m. The policy indicated but was not limited to, "17. 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 any residue, for example blood. Hold the limbs until the antiseptic has dried." ... "18. Attach sterile 10 ml syringes to the arterial and venous limbs." ... "25. After a minimum of 3-5 minutes, remove the syringe from each access port one at a time, then attach each blood line carefully, as not to contaminate blood line tips or catheter limbs." ... "Upon Completion of Dialysis" ... "29. Discard existing barrier and place a new clean, moisture proof barrier under the catheter to prevent contamination." 2. During an observation on 2/20/2023 at 1:21 p.m. of Patient 1, initiating a CVC, PCT C was observed placing a new moisture barrier under the limbs of the CVC, securing it in place. Patient 1 was observed continually speaking with staff with face mask present but not completely covering his lower mouth and chin and resting his hands across his chest on this moisture barrier just placed, waiting for PCT C to start the dialysis treatment. PCT C was then observed removing the caps on the arterial and venous limbs of the CVC, cleaning each limb with an alcohol pad, then laying the sterile, open ends of the CVC limbs down on the moisture barrier placed below the catheter. PCT C then was observed removing the plastic wrapping on two, 10 ml syringes, picking up the limbs and attaching the syringes to the arterial and venous limbs. PCT C was then observed removing the 10 ml syringes from the		2020-0115, and Procedure 1-04-02B “Central Venous Catheter (CVC) With ClearGuard HD Antimicrobial End Caps Procedure” with emphasis on but not limited to: Procedure Steps [Initiation]: 1) Step #2: Set-up clean field with supplies on a clean moisture proof barrier. 2) Step #3: Place a second moisture proof barrier under catheter limbs. 3) Step #16: 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 any residue, for example blood. Hold the limbs until the antiseptic has dried. 4) Step #17: Attach sterile 10ml syringes to the arterial and venous limbs. 5) Step #24: After a minimum of three to five (3-5) minutes, remove syringe from each access port one at a time, then attach each blood line carefully, as not to contaminate blood line tips or catheter limbs. “Upon Completion of Dialysis”: 1) Step #28: Discard existing barrier and place a new clean, moisture proof barrier under catheter to prevent contamination. Verification of attendance is evidenced by teammate’s signature on the in-service sheet. Laminated copies of the Quick Care Reminder Card were placed	

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	catheter limbs, laying the open ends of the limbs on the moisture barrier, retrieving the blood lines from the dialysis machine, then connecting the limbs to the blood lines. 3. During an observation on 2/20/2023 at 4:41 p.m. of Patient 1, discontinuing a CVC, PCT K was observed discontinuing Patient 1's hemodialysis CVC treatment without replacing the moisture barrier that had been placed during the initiation of dialysis. 4, During an interview on 2/20/2023 at 2:14 p.m. with the ROD (Regional Operations Director), MCS (Manager of Clinical Services, and FA (Facility Administrator), all were notified of the observation with the initiation of the CVC for Patient 1. The MCS agreed that placing the open end of the CVC limbs down on the moisture barrier was a breach in infection control related to CVC's. 5. During an interview on 2/20/2023 at 5:14 p.m. during the daily conference update, the ROD, FA, and MCS were notified that during the observation of the discontinuation of the CVC for Patient 1, the moisture barrier was not replaced with a new one. All agreed that it should be changed when discontinuing treatment.		appropriately in the clinic on 02/21/23. The Facility Administrator or designee will conduct observational audits to verify CVC care is completed in compliance with policy and procedure: daily for two (2) weeks then, then weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the audit results with teammates during homeroom meetings, and with the Medical Director during monthly Quality Assessment and Performance Improvement meetings known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0544 Bldg. 00	494.90(a)(1) POC-ACHIEVE ADEQUATE CLEARANCE Achieve and sustain the prescribed dose of dialysis to meet a hemodialysis Kt/V of at least 1.2 and a peritoneal dialysis weekly Kt/V of at least 1.7 or meet an alternative equivalent professionally-accepted clinical practice standard for adequacy of dialysis. Based on record review and interview, the facility failed to ensure the physician ordered BFRs	V 0544	The Facility Administrator or designee held mandatory in-services for all clinical	03/28/2023

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	(blood flow rate) were achieved during the hemodialysis treatments in 3 of 5 patient records reviewed. (Patient 2, Patient 4, & Patient 5) Findings Include: 1. A policy titled, "Pre-Intra-Post Treatment Data Collection, Monitoring, and Nursing Assessment," dated April 2020 was provided by the facility administrator on 2/22/2023 at 10:17 a.m. The policy indicated but was not limited to, "10. If the dialysis prescription is not being met (including dialysis flow rate or change to/inability to obtain prescribed blood flow rate) the reason will be documented and the licensed nurse informed." 2. Hemodialysis treatment sheets reviewed on 2/21/2023 for Patient 2 indicated a physician ordered BFR of 400 ml/min (milliliters per minute) The following dates indicated BFRs achieved during treatments without adequate documentation supporting the change in BFR: 1/2/2023 BFR of 350 1/4/2023 BFR of 340 3. Hemodialysis treatment sheets reviewed on 2/21/2023 for Patient 4 indicated a physician ordered BFR of 450 ml/min (milliliters per minute) The following dates indicate BFRs achieved during treatments without adequate documentation supporting the change in BFR: 2/13/2023 BFR of 400 2/17/2023 BFR of 340 4. Hemodialysis treatment sheets reviewed on 2/21/2023 for Patient 5 indicated a physician ordered BFR of 400 ml/min (milliliters per minute)		teammates starting on 02/22/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 1-03-08 “Pre- Intra- Post Treatment Data Collection, Monitoring and Nursing Assessment” with emphasis on but not limited to: 1) Patient identity, prescription and machine settings are verified by teammates prior to initiation of treatment. Prescription components include but are not necessarily limited to... Blood Flow rate ... 2) If the dialysis prescription is not being met [including dialysis flow rate or change to/inability to obtain prescribed blood flow rate] the reason will be documented and the licensed nurse informed. 3) All findings, interventions and patient response will be documented in the patient’s medical record. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. Facility Administrator or designee will conduct audits to verify teammate documentation of abnormal findings, notification given to the licensed nurse, and the appropriate response by the nurse to the findings: on twenty five percent (25%) of the treatment records daily for two (2) weeks, then weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly ten	

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	The following dates indicate BFRs achieved during treatments without adequate documentation supporting the change in BFR: 2/17/2023 BFR of 350 5. During an interview with the FA (facility administrator) on 2/22/2023 at 8:50 a.m., the FA was notified of the above findings and was not able to provide any further documentation.		percent (10%) medical records audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the audit results with teammates during homeroom meetings, and with the Medical Director during monthly Quality Assessment and Performance Improvement meetings known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0715 Bldg. 00	494.150(c)(2)(i) MD RESP-ENSURE ALL ADHERE TO P&P The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; Based on record review, observation, and interview the facility failed to ensure that the policy was followed regarding the use of tourniquets when cannulating (inserting dialysis needles) an AVF (Arteriovenous Fistula) in 2 of 2 AVF observations (Patient 4 & Patient 6). Findings Include:	V 0715	A Governing Body meeting was held on 03/02/23, with the Medical Director, Facility Administrator, Director of Nursing and Regional Operations Director was held and reviewed the results of the survey ending on 02/22/23. The Governing Body reviewed Policy COMP-DD-017 “Medical Director Qualifications and	03/28/2023

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	1. A policy titled, "Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care" dated April 2022 was provided by the FA (facility administrator) on 2/20/2023 at 1:05 p.m. The policy indicated, but was not limited to, "10. Fistula requires a tourniquet for cannulation (some patients may prefer to manually simulate a "tourniquet" with their non access hand)". 2. A policy titled, "AV Fistula or Graft Cannulation with Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of Heparin Loading Dose," dated April 2019 was provided by the MCS (Manager of Clinical Services) on 2/20/2023 at 3:36 p.m. The policy indicated but was not limited to, "15. Apply a new tourniquet for cannulating AV fistula or graft. Apply to the extremity above the fistula or graft firmly enough to impede but not occlude venous flow. Remove the tourniquet post cannulation. A tourniquet should be used to distend the fistula even when vessel does not appear to require it. A tourniquet may also be used to distend and stabilize an easily compressible graft." ... "23. Tourniquet should be left in place only for the short time required to distend the access for needle cannulation. Prolonged compression may lead to stenosis of the vessels." 3. During an observation 2/20/2023 at 12:01 p.m. a PCT (patient care technician) was observed initiating Patient 4's hemodialysis treatment, an AVF. No tourniquet was placed on the access arm prior to cannulating the AVF. 4. During an observation 2/20/2023 at 12:16 p.m. a PCT was observed initiating Patient 6's hemodialysis treatment, an AVF. No tourniquet was placed on the access arm prior to cannulating the AVF.		Responsibilities" with the Medical Director, who acknowledges that he/she is responsible to ensure the facility teammates are trained and follow policy and procedure relative to patient admissions, patient care, infection control, and safety. Plans of correction have been developed and initiated to correct identified deficiencies and to sustain compliance. The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 02/22/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 1-04-01 "Arteriovenous Fistula (AVF) and Arteriovenous Graft (AVG) Vascular Access Care" with emphasis on but not limited to: 1) Fistula requires a tourniquet for cannulation... 2) For cannulation, a tourniquet may be helpful in engorging easily compressible grafts. A tourniquet may be placed on the extremity above the graft immediately prior to cannulation and removed	

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	5. An interview was conducted with Patient 4 on 2/20/2023 at 12:15 p.m. Patient 4 indicated that the AVF was placed several years ago, and a tourniquet is not used to cannulate. 6. An interview was conducted with Patient 6 on 2/20/2023 at 12:30 p.m. Patient 6 indicated that the AVF was placed approximately 2 years ago, and a tourniquet is not used to cannulate. 7. An interview was conducted with the charge nurse on 2/20/2023 at 1:05 p.m. The charge nurse indicated that tourniquets are not used on AVF's that are mature, only newer AVF's due to concerns of "blowing the access". Indicated that some patients prefer not to use tourniquets. 8. An interview was conducted with the medical director on 2/22/2023 at 3:23 p.m. The medical director indicated being aware that tourniquets are not always being used to cannulate AVF's due to concerns regarding clotting of AVF's.		immediately after needle placement. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. The Facility Administrator or designee will conduct observational audits to verify the use of tourniquets when cannulating AV fistulas and grafts: on twenty five percent (25%) of the patients daily for two (2) weeks, then (25%) weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly ten percent (10%) medical records audits. Instances of non-compliance will be addressed immediately. The Medical Director will review progress of teammate education, results of audits, and adherence to this plan of correction during monthly Quality Assessment and Performance Improvement meetings known as Facility Health Meeting. The Facility Administrator will report progress, as well as any barriers to maintaining compliance, with supporting documentation included in the meeting minutes. Action plans will be evaluated for effectiveness, new plans developed as applicable to achieve compliance with teammate adherence to policy and procedure. The Facility Administrator on behalf of the Governing Body is responsible for	

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			compliance with this plan of correction.	
V 0726 Bldg. 00	494.170 MR-COMPLETE, ACCURATE, ACCESSIBLE The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. Based on record review and interview, the facility failed to ensure a complete and accurate medical record was maintained to include signed patient documentation for shortened treatments, AMA's (Against Medical Advice), for 1 of 5 patients reviewed. (Patient 2) Findings Include: 1. A policy titled, "CWOW-Prescribed Treatment Time Not Met," dated April 2022 was provided by the FA (Facility Administrator) on 2/22/2023 at 10:17 a.m. The policy indicated but was not limited to, "Completion of the Early Termination of Treatment Against Medical Advice Form" ... "1. The RN will verify that a patient signs the Early Termination of Treatment Against Medical Advice form any time the patient requests to terminate their treatment earlier than the prescribed run time." ... "3. The RN will obtain the patient's signature on the Early Termination Treatment Against Medical Advice form prior to the patient being rinsed back from their treatment. If unable to obtain the patient's signature prior to rinse-back, the RN will obtain the patient's	V 0726	The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 02/22/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 1-01-09 "CWOW-Prescribed Treatment Time Not Met" with emphasis on but not limited to: 1) The Registered Nurse (RN) will verify that a patient signs the *"Early Termination of Treatment Against Medical Advice*" form any time the patient requests to terminate their treatment earlier than the prescribed run time. 2) The RN will obtain the patient's signature on the "*Early Termination of Treatment against Medical Advice"* form prior to the patient being rinsed back from their treatment. If unable to obtain the patient's signature prior to rinse-back, the RN will obtain the patient's	03/28/2023

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	signature on the form prior to the patient's departure from the facility." ... "5. If a patient refuses to sign the Early Termination of Treatment Against Medical Advice form, the RN will document the patient's refusal with the words "patient refused" in the patient signature box along with the date. Under such circumstances, the RN will sign the form and will also obtain a witness signature on the form." 2. Treatment records reviewed on 2/21/2023 for Patient 2 indicated the following shortened treatments which were missing Early Termination of Treatment Against Medical Advice forms completed. 12/30/2022 Prescribed Treatment Time = 4 hours 0 minutes (240 minutes) Start Time: 11:50 a.m. End Time: 14:51 p.m. Total Run Time: 3 hours and 1 minute 1/4/2023 Prescribed Treatment Time = 4 hours 0 minutes (240 minutes) Start Time: 11:23 a.m. End Time: 14:09 p.m. Total Run Time: 3 hours and 35 minutes 1/9/2023 Prescribed Treatment Time = 4 hours 0 minutes (240 minutes) Start Time: 11:20 a.m. End Time: 14:55 p.m. Total Run Time: 3 hours and 35 minutes 1/18/2023 Prescribed Treatment Time = 4 hours 0 minutes (240 minutes) Start Time: 12:58 p.m. End Time: 15:20 p.m. Total Run Time: 2 hours and 22 minutes		signature on the form prior to the patient's departure from the facility. 3) The RN must countersign all *"Early Termination of Treatment against Medical Advice"* forms. A witness signature is required only if the patient refuses to sign the form. 4) 5. If a patient refuses to sign the *"Early Termination of Treatment against Medical Advice"* form, the RN will document the patient's refusal with the words "patient refused" in the patient signature box along with the date. Under such circumstances, the RN will sign the form and will also obtain a witness' signature on the form. Verification of attendance at in-service will be evidenced by teammates signature on in-service sheet. The Facility Administrator or designee will conduct an audit to verify *"Early Termination of Treatment against Medical Advice"* form is completed when treatment time completed does not meet the physician's order for treatment: on twenty five percent (25%) of the treatment records daily for two (2) weeks, then weekly for two (2) weeks. Ongoing compliance will be monitored with the monthly ten percent (10%) medical records audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the audit	

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	3. During an interview with Charge Nurse on 2/22/2023 at 8:50 a.m., the Charge Nurse indicated that nursing staff always try to educate patients on the importance of treatment adherence and complete an Early Termination of Treatment Against Medical Advice form including the patient's signature, however, it is not always done due to patient circumstances. In relation to Patient 2, would frequently want to end treatment due to diarrhea and form was not always completed. Agreed that this is DaVita's policy.		results with teammates during homeroom meetings, and with the Medical Director during monthly Quality Assessment and Performance Improvement meetings known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0800 Bldg. 00	494.30 (b)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff § 494.30 Condition: Infection control. (b) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its patients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its patients, under contract or by other			

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	arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with patients and other staff specified in paragraph (b)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with patients and other staff specified in paragraph (b)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (b)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its patients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status for all staff specified in paragraph (b)(1)			

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	of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination			

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	status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (b)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on record review and interview, the facility failed to ensure their COVID-19 Vaccination Policies and Procedures included additional precautions to be implemented to mitigate the spread of COVID-19 (infectious respiratory disease) for unvaccinated staff that provided direct patient care in the treatment area that went above standard precautions currently in place for 1 of 1 facility reviewed. Findings include: 1. A March 2022 policy titled "Covid-19 Vaccination Policy for Dialysis Facilities and Programs" was provided by the manager of clinical services on 02/22/2023 at 5:01 p.m. The policy indicated but was not limited to, "7.	V 0800	The Facility Administrator or designee held mandatory in-services for all clinical teammates starting on 03/10/23. Surveyor observations were reviewed. Education included but was not limited to a review of Policy 4-06-08 “COVID-19 Vaccination Policy for Dialysis Facilities and Programs” with emphasis on but not limited to: 1) Contingency plan for teammates who are not fully vaccinated; teammates with approved exemptions, or who are not yet fully vaccinated, or who have a temporary delay will be required to abide by all applicable DaVita	03/28/2023

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	Contingency plan for teammates that are not fully vaccinated: ... abide by all applicable DaVita guidance related to COVID precautions (e.g., physical distancing, masking, screening, cleaning, and disinfection, etc.) and infection control policies and practices, (e.g., DaVita Breakroom Guidance which requires wearing a mask in breakroom when not eating, staggering teammate breaks to limit number of teammates in room at one time, and social distancing of 6 ft)." 2. During an interview with the MCS (manager of clinical services), FA (facility administrator), and ROD (regional operations director) on 2/20/2023 at 2:24 p.m., the ROD indicated that all employees are following all CDC recommendation. The ROD also indicated being aware that this facility would be "hit" on additional precautions for the unvaccinated due to history of previous surveys at other DaVita facilities and expecting the same with this facility. 3. During an interview with the MCS on 2/22/2023 at 5:02 p.m. the MCS indicated that the policy will not be changed by DaVita because no other states are seeing this citation.		guidance related to COVID precautions (e.g., physical distancing, masking, screening, cleaning and disinfection, etc.) and infection control policies and practices (e.g., DaVita breakroom guidance which requires wearing a mask in breakroom when not eating, staggering teammate breaks to limit number of teammates in room at one time, and social distancing of 6 feet). *"Attachment N for ESRD facility for QSO-22-09-ALL Memorandum"* revised on 4/5/22: Guidance for the Interim Final Rule- Medicare and Medicaid Programs: Omnibus COVID-19 Health Care Staff Vaccination states that "The policy must also ensure those staff who are not yet fully vaccinated, or who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19. This requirement is not explicit and does not specify actions that must be taken; there are a variety of actions or job modifications that a facility may implement to potentially reduce the risk of COVID- 19 transmission, examples including but not limited to: Requiring staff who have not completed their primary vaccination series to follow additional, CDC recommended	

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			precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e. g. staff meeting rooms, kitchen)….” DaVita policy incorporates this requirement and goes above the CDC-recommended precautions for unvaccinated teammates. Because DaVita has unvaccinated teammates in the facility, all people (including unvaccinated teammates) who enter the facility are required to do a verbal attestation confirming lack of COVID-19 symptoms and must have his/her temperature taken and documented upon entry. Also all patients and teammates (including unvaccinated teammates) are required to wear a medical grade mask at all times while in the facility. Additionally, DaVita requires all teammates (including unvaccinated teammates) to undertake extra precautions when in the breakroom since this is a time when he/she will potentially be without a mask while eating and drinking. The additional precautions for the breakroom include social distancing, staggering breaks to minimize the number of people in the room at one time, and continuing to mask unless eating or drinking. All of these measures are additional precautions that DaVita requires of	

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			all teammates (including unvaccinated teammates) throughout its facilities in order to mitigate the spread of COVID-19. Verification of attendance is evidenced by teammate's signature on the in-service sheet. The Facility Administrator or designee will conduct a COVID-19 Field Audit Tool weekly for four (4) weeks to verify that all teammates, including unvaccinated teammates are following the policy. Results of audits will be reviewed with Medical Director during monthly Quality Assessment and Performance Improvement meetings known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for ongoing compliance with this plan of correction.	