STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152682	A. BUILDING 00 B. WING	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLES DIALYSIS	5301 PEARL DR EVANSVILLE, IN 47712

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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: April 5-8, 2021 Facility Number: 014204 Census = 33 in-center At this Emergency Preparedness survey, Eagles Dialysis was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 494.62 Quality Review completed on 4/21/2021 A4	E 0000		
E 0028 Bldg. 00	494.62(b)(9) Dialysis Emergency Equipment [(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction,			

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

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	defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available. Based on observation, record review, and interview, the facility failed to ensure a process was in place by which staff could confirm that emergency medication was available for use for 1 of 1 crash cart medication kits. Findings include: A revised April 2018 policy titled, "PHYSICAL ENVIRONMENT" was provided by the Administrator on 4/8/2021 at 11:23 a.m. The policy indicated, but was not limited to, "The dialysis facility will implement and maintain a program to verify that all equipment, including emergency equipment ... are maintained ..." During an observation on 4/5/2021 at 8:50 a.m., a crash cart medication kit containing emergency medications was observed without an accompanying emergency medication checklist. During an interview on 4/15/2021 at 9:00 a.m., RN C stated there was a checklist [for emergency supplies] in a designated binder but a specific emergency medication checklist was not used.	E 0028	**E 028** 100% of licensed nurses will be in-serviced on Policy 8-04-01 "Physical Environment" and Policy 12-02-08 "Emergency Equipment Checks" by the Facility Administrator (FA) beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed with emphasis on: 1) The dialysis facility will implement and maintain a program to verify that all equipment, including emergency equipment…are maintained…2) the emergency checklist will be developed by the facility based on Medical Director input as to the supplies needed on the emergency (crash) cart and will be used to verify that the cart has been checked. 3) A list of all dated supplies will be posted, with expiration dates, on the cart and is to be checked weekly by licensed nurse teammate assigned to check the emergency cart. On 4/22/21, the Governing Body adopted and approved a Crash Cart Emergency Medication Checklist Template. The FA or designee will audit the Emergency cart (crash cart) medication checklist daily x 1 week and then weekly x 4 weeks to verify compliance with facility policy.	05/07/2021

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			Ongoing compliance will be verified with the weekly emergency cart audit. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
E 0033 Bldg. 00	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of			

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	patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility failed to update the dialysis prescriptions and emergency contact information binder for the evacuation kit reviewed, with the potential to affect 33 of 33 dialysis patients during an emergency evacuation. Findings include: A revised April 2019 policy titled, "EVACUATION KIT," indicated, but was not limited to, "6. Each evacuation kit(s) should contain: a) Copy of each patient's treatment orders and medication list. The Facility Administrator (FA) or designee will verify patient information is updated and replaced at least monthly." During a review of the Evacuation Kit on 4/5/2021 at 8:50 a.m., the dialysis prescriptions and emergency contact information was dated 2/27/2021. During an interview on 4/5/2021 at 12:18 p.m., the Manager of Clinical Services indicated the facility	E 0033	**E033** 100% of teammates will be in-serviced on *Policy 4-07-02 "Evacuation Kit"* beginning 4/22/21. Verification will be evidenced by a signature sheet. Teammates will be were instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Each evacuation kit(s) should contain: Copy of each patient's treatment orders, and medication list. The Facility Administrator (FA) of designee will verify patient information is uploaded and replaced at least monthly. The FA or designee will audit the Evacuation Kit weekly x 4 weeks and then monthly x 3 months to verify compliance with facility policy. Ongoing compliance will be verified monthly with the Evacuation Kit audit. The FA will	05/07/2021

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	"tries to update contacts monthly." The Administrator indicated the dialysis prescriptions were updated monthly.		review audit results with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
E 0039 Bldg. 00	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the			

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	full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based			

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	functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:			

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	(A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual			

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	exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the			

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	emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility- based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. Based on record review and interview, the facility failed to maintain accurate documentation for 2 of 2 emergency drills reviewed. Findings include: 1. An undated document titled, "Quarterly Mock Fire Drill" was provided on 4/8/2021 at 11:21 am. It indicated, but was not limited to, " 4. Fill out Drill Evacuation Form..." 2. An August 2017 Health and Safety Policy & Procedure document was provided on 4/8/2021 at 9:49 a.m. It included four parts: a scenario template, a supplemental information sheet, an exercise attendance sheet, and a facility emergency exercise drill evaluation. The scenario template indicated the drill as fire inside facility with the date completed as January 2020. The last two digits of the year were marked over with a pen to make the date read January 2021. The exercise attendance sheet indicated January 2020. The facility emergency exercise drill evaluation indicated the date as 12-29-20, was struck out, and above it written 1-29-21. The date box next to the signature at the bottom of the evaluation form indicated 1-29-20, but the last two digits of the year were marked over with a pen, to read 1-29-21. 3. An August 2017 Health and Safety Policy & Procedure document was provided on 4/8/2021 at 9:49 a.m. It included four parts: a scenario template, a supplemental information sheet, an exercise attendance sheet, and a facility emergency exercise drill evaluation. The scenario	E 0039	**E 039** 100% of teammates will be in-serviced on *Policy 7-02-05 "Facility Emergency Management Plan" b*eginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Emergency drill shall be conducted by FA, or designee: Fire safety drills: Required on a QUARTERLY basis…Utilize "Emergency Exercise Template "FIRE WITHIN FACILITY": Emergency event drill template, Drill evaluation, and Teammate attendance sheet. 2) Facility emergency preparedness drill: …Complete one (1) drill on an ANNUAL basis – Participate in a full-scale exercise with local emergency management agency this is community-based – If one is not available, an individual, facility-based exercise may be done. 3) Conduct an additional exercise opposite the year full-scale exercise is completed. 4) Utilize "Emergency Exercise Templates: Emergency event drill template, Drill evaluation, and Teammate attendance sheet. A	05/07/2021

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	template indicated a winter storm with the date completed as 12-27-20. The last two digits of the year were marked over with a pen to make the date read 12-27-21. The date was then struck out with a pen, and 1-27-21 written above. The facility emergency exercise drill evaluation indicated the date as 12-27-20. The two digit month, and last two digits of the year were marked over with a pen to make the date read 1-27-21. The date was then struck out with a pen, and 1-27-21 written above. The date box next to the signature at the bottom of the evaluation form indicated 12-27-20, but was struck out and 1-27-21 written above. 4. During an interview on 4/8/2021 at 8:36 a.m., the Administrator stated that he/she was gone during that timeframe and did not know why the dates were changed on the Health and Safety Policy & Procedure documents. The Administrator stated that maybe the dates were wrong. 5. During an interview on 4/8/2021 at 8:45 a.m., the Administrator indicated the dates on the Health and Safety Policy and Procedure documents were recorded as when they were due. The dates were recorded incorrectly and that was why they were changed. The Administrator was unsure why the exercise attendance sheet for the fire inside building scenario indicated January 2020.		Quarterly Fire Safety Drill was completed on 3/9/21 and documented on the Emergency Exercise Template "FIRE WITHIN FACILITY". An emergency preparedness drill is scheduled to be completed during June 2021. The exercise will be documented on the "Emergency Exercise Template". The Facility Administrator (FA) or designee will audit the facility Emergency Management Plan Quarterly to verify compliance with facility policy. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion date: 5/7/21	
V 0000 Bldg. 00	This survey was for a federal ESRD (Core) recertification in conjunction with a Covid-19 infection control survey. Survey Dates: April 5-8, 2021	V 0000		

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	152682	A. BUILDING 00 B. WING	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLES DIALYSIS	5301 PEARL DR EVANSVILLE, IN 47712

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	Facility Number: 014204 Census: 33 in-center hemodialysis No home peritoneal dialysis offered No home hemodialysis offered			
V 0111 Bldg. 00	494.30 IC-SANITARY ENVIRONMENT The dialysis facility must provide and monitor a sanitary environment to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas. Based on observation, record review, and interview, the facility failed to ensure a sanitary environment was maintained in order to minimize the transmission of infectious agents within and between the unit and any adjacent hospital or other public areas for 1 of 1 patient transfer observations (Station 1); and for 2 of 2 staff observations. (Physician N, PCT G, RN C) Findings include: 1. A revised October 2020 policy titled Infection Control for Dialysis Facilities was provided by the Manager of Clinical Services on 4/5/2021 at 2:45 p.m. The policy indicated, but was not limited to, "It is recommended that all non-DaVita clinicians (physicians, NPs [nurse practitioners], PAs [physician assistants], physician extenders, case managers) and other DaVita Teammates providing services in the facilities ... adhere to this policy ... Per Conditions for Coverage (CfC) Interpretive Guidelines, visitors must be provided fluid resistant/fluid impervious cover garments if they are in the treatment area during initiation or termination of dialysis ... Appropriate PPE (personal protective equipment) will be worn whenever there is a potential for contact with	V 0111	**V 111** 100% of teammates, including Biomedical teammates, Physicians, Non-Physician Practitioners, and Emergency Medical personnel will be in-serviced on Policy 1-05-01 beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates and visiting personnel will to be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) It is recommended that all non-DaVita clinicians (physicians, NPs, PAs, Physician extenders, case managers) and other DaVita teammates providing services in the facilities adhere to this policy. 2) Appropriate PPE will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment, and environmental surfaces…PPE is	05/07/2021

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	body fluids... PPE is to be removed prior to leaving the treatment area ... Physicians, NPs, social workers and dietitians will wear PPE when in the treatment area..." 2. During an observation on 4/5/2021 at 2:27 p.m. two hospital EMT's (emergency medical technicians) were observed in the treatment area transferring a patient near station 1 from the stretcher to a treatment chair for dialysis. The two EMT's were without gowns and face shields, and 1 EMT was without gloves. The facility failed to enforce their own policy. 3. During an observation on 4/7/2021 at 8:15 a.m. observed Physician N in the treatment area examining patients without a face shield or eye wear. 4. During an observation on 4/7/2021 at 1:00 p.m. observed RN (Registered Nurse) C and PCT (Patient Care Technician) G wear their gowns, gloves, masks, and face shields out of the treatment area and into the patient waiting area. 5. During an interview on 4/6/2021 at 2:12 p.m. the Medical Director indicated he/she expected the staff to wear appropriate personal protective equipment while in the treatment area. 6. During an interview on 4/7/2021 at 3:00 p.m. the Administrator stated the physician refused to wear a face shield.		to be removed prior to leaving the treatment area. 3) Physicians, NPPs, social workers, and dietitians will wear PPE when in the treatment area. PPE is to be removed prior to leaving the treatment area. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks, and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly Infection Control audit. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health meeting. The FA is responsible for ongoing compliance with facility policy. Completion Date: 5/7/21	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or			

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	station. Based on observation and record review, the facility failed to ensure gloves were worn and changed appropriately, and hand hygiene was performed effectively for 4 of 10 patient care observations (Patient 3, 5, 10, 11). Findings include: 1. A revised October 2020 policy titled, "INFECTION CONTROL FOR DIALYSIS FACILITIES" indicated, but was not limited to, "1. Hand hygiene is to be performed ... prior to gloving, after removal of gloves, after contact with blood or other infectious material, after patient and dialysis delivery system contact ... before touching clean areas such as supplies ... 11. Teammates will wear disposable gloves when ... touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 12. Gloves should be worn when: ... Touching the ... dialysis delivery system during or after a dialysis treatment. 13. Gloves should be changed when: ... When going from a "dirty" area or task to a "clean" area or task. When moving from a contaminated body site to a clean body site of the same patient." 2. During an observation on 4/7/2021 at 8:07 a.m., RN (Registered Nurse) C used a glove bunched up in his/her hand to push buttons on the dialysis machine at Patient #11's station. RN C typed into the computer, failed to perform hand hygiene, and then donned gloves. RN C failed to perform hand hygiene between glove changes multiple times during the initiation of Patient #11's dialysis treatment. 3. During an observation on 4/7/2021 at 8:30 a.m.,	V 0113	**V 113** 100% of clinical teammates will be in-serviced on Policy 1-05-01 "Infection Control for Dialysis Facilities" beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Hand Hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies and on exiting the patient treatment area. 2) Teammates will wear disposable gloves when…touching the patient's equipment at the dialysis station, and will remove gloves and wash hands or perform hand hygiene between each patient and/or station. 3) Gloves should be worn when: Touching the…dialysis delivery system during or after a dialysis treatment…4) Gloves should be changed: When going from a "dirty" area or task to a "clean" area or task. When moving from a contaminated body site to a clean body site of the	05/07/2021

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	RN C accessed Patient #5's belongings in his/her personal bag, moved the television into the viewing area, and connected Patient #5's fistula access lines to the dialysis machine without performing glove change and hand hygiene. RN C used a glove bunched up in his/her hand to push buttons on the dialysis machine at Patient #5's station. 4. During an observation on 4/7/2021 at 9:09 a.m., PCT I rolled back the old CVC (central venous catheter) dressing (dirty) and placed a clean field under Patient #10's CVC ports while wearing the same gloves. PCT I was observed touching the old CVC dressing (dirty) and then flushing the CVC lines (clean) while wearing the same gloves. 5. During an observation on 4/7/2021 at 8:30 a.m. patient 3 was observed holding pressure to his/her left access site after needles were removed with a gloved hand. Patient 3 removed the glove and did not perform hand hygiene prior to leaving the station. Patient 3 was accompanied to the weight scale by PCT (patient care technician) G and then left the treatment area and facility. PCT G failed to offer hand sanitizer to patient 3 prior to leaving the treatment area or provide education about hand hygiene after glove removal.		same patient. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks, and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly infection control audit. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
V 0117 Bldg. 00	494.30(a)(1)(i) IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples			

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	are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. Based on observation, record review, and interview, the facility failed to ensure cross contamination between patient supplies for 2 of 4 survey days. (Stations 1 to 13); and failed to ensure staff member's personal items were not kept in a designated clean treatment area for 1 of 3 clean station observations. Findings include: 1. A revised October 2020 policy titled Infection Control for Dialysis Facilities was provided by the Administrator on 4/5/2021 at 2:45 p.m. The policy indicated, but was not limited to, "Teammates will not store extra dialysis supplies, for example, saline and blood lines, on countertops near patient stations where contamination of such supplies could possibly occur." 2. During the flash tour on 4/5/2021 at 9:00 a.m. observed stations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 , 11, 12, and 13. Bags of normal saline, IV (intravenous) tubing, syringes, and needles were stored on the counter top directly behind each dialysis machine and patient treatment chairs ready for the second	V 0117	**V 117** 100% of clinical teammates will be in-serviced on Policy 1-05-01 “Infection Control for Dialysis Facilities” beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) teammates will not store extra dialysis supplies, for example, saline and blood lines, on countertops near patient stations where contamination of such supplies could possible occur. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks, and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the	05/07/2021

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	shift. At 9:15 a.m. RN (Registered Nurse) C was interviewed and stated the counter tops were considered clean, but they wipe the counter tops after the patients leave the station. At 9:35 a.m. observed staff member's personal sound system sitting on the counter next to a clean sink. The facility failed to ensure cross contamination between patients supplies, and failed to ensure personal items were not kept in a designated clean area. 3. During an observation on 4/5/2021 at 10:00 a.m. a personal stereo sound equipment was sitting on the counter in the designated clean sink area. 4. During an observation on 4/7/2021 at 7:15 a.m. observed stations 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13. Bags of normal saline, IV tubing, syringes, and needles were stored on the counter top directly directly behind each dialysis machine and patient treatment chairs ready for the second shift. 5. During an interview on 4/8/2021 at 11:30 a.m. the Administrator was made aware of the extra dialysis supplies on countertops directly behind patient stations for the next shift. No additional comments or information was provided.		monthly infection control audit. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
V 0122 Bldg. 00	494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.			

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	Based on observation and record review, the facility failed to follow applicable infection control procedures when cleaning and disinfecting contaminated surfaces and equipment for 1 of 2 treatment stations being cleaned (Station 12). Findings include: A revised October 2020 policy titled, "INFECTION CONTROL FOR DIALYSIS FACILITIES" was provided by the Administrator on 4/5/2021 at 2:45 p.m. The policy indicated, but was not limited to, "46. Equipment including ... television arms and control knobs ...if accessible to patients and teammates, ... will be wiped clean with a bleach solution of the appropriate strength ... after each treatment." During an observation of cleaning and disinfecting dialysis station 12 on 4/7/2021 at 7:47 a.m., PCT I failed to clean and disinfect the television following dialysis treatment.	V 0122	**V 122** 100% of clinical teammates will be in-serviced on Policy 1-05-01 "Infection Control for Dialysis Facilities" beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Equipment including…television arms and control knobs…if accessible to patients and teammates…will be wiped down with a bleach solution of the appropriate strength…after each treatment. The Facility Administrator (FA) or designee will conduct observational audits daily x 2 weeks and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly infection control audit. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	05/07/2021
V 0143 Bldg. 00	494.30(b)(2) IC-ASEPTIC TECHNIQUES FOR IV MEDS [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and			

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	ampules; and Based on observation and record review, the facility failed to properly disinfect the medication vial stopper for 2 of 2 medication preparation observations (RN C). Findings include: 1. A revised April 2021 policy titled, "MEDICATION POLICY' was provided by the Administrator on 4/6/2021 at 12:35 p.m. The policy indicated, but was not limited to, "21. An ... aseptic technique is used when preparing medication." 2. A revised September 2016 policy titled, "PREPARATION AND ADMINISTRATION OF INTRAVENOUS MEDICATION" was provided by the Administrator on 4/6/2021 at 7:45 a.m. The policy indicated, but was not limited to, "6. Remove the vial cap and clean vial stopper with an alcohol prep pad." 3. During an observation on 4/5/2021 at 1:45 p.m., RN C opened an alcohol prep pad and placed it on the countertop in the clean area, tapped the Epogen vial stopper twice on the alcohol prep pad, and drew up the medication with a needle and syringe. RN C then tapped the Venofer vial stopper twice on the alcohol prep pad, and drew up the medication with a needle and syringe. RN C failed to swab each vial using an appropriate aseptic technique.4. During an observation on 4/5/2021 at 1:40 p.m. RN C prepared IV medications Venofer (low iron), Hecterol (vitamin D), and Epogen (low blood count) for patient 14. RN C placed the alcohol pad on the counter, inverted each vial, and dabbed the vial twice on the alcohol pad. RN C failed to swab each vial using an appropriate aseptic technique.	V 0143	**V143** 100% of clinical teammates will be in-serviced on *Policy 1-06-01 "Medication Policy" and Policy 7-06-07A "Preparation and Administration of Intravenous Medication"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) ...aseptic technique is used when preparing medications. 2) Remove the vial cap and clean vial stopper with an alcohol prep pad. The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly with the infection control audit. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	05/07/2021

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V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children 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 observation and record review, the facility failed to ensure the CVC (central venous catheter) site was allowed to dry the recommended 60 (sixty) seconds before application of a sterile dressing in 1 of 2 exit site care observations (Patient 12).	V 0147	**V147** 100% of clinical teammates will be in-serviced on *Policy 1-04-02B "Central Venous Catheter (CVC) with Clearguard HD Antimicrobial End Caps Procedure"* beginning	05/07/2021

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	Findings include: An April 2019 policy titled, "CENTRAL VENOUS CATHETER (CVC) WITH CLEARGUARD HD ANTIMICROBIAL END CAPS PROCEDURE" was provided by the Administrator on 4/7/2021 at 10:25 a.m. The policy indicated, but was not limited to, "Device Disinfectant and Skin Antiseptic: 2% Chlorhexidine/70% Isopropyl Alcohol, Effective for: CVC access exit site, Effective Volume: 1 prepackaged swab ... Air Drying Time: 60 seconds." During an observation on 4/7/2021 at 9:31 a.m., PCT F cleansed the area around the CVC exit site for Patient #12 with a Chloraprep (2% Chlorhexidine Gluconate/70% Isopropyl Alcohol) single swab, and allowed it to dry for 8 seconds prior to applying a sterile dressing.		4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) **Device Disinfectant and Skin Antiseptic**: 2% Chlorhexidine/70% Isopropyl Alcohol; **Effective for:** CVC exit site; **Effective Volume:** 1 pre-packaged swab; **Air Drying Time:** 60 seconds. The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week, then 3 x weekly x 2 weeks, and then weekly x 4 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly infection control audit. The FA will review audit results with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date 5/7/21	
V 0401 Bldg. 00	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.			

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EAGLES DIALYSIS	5301 PEARL DR EVANSVILLE, IN 47712

(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
	Based on observation, record review, and interview, the facility failed to provide adequate lighting to maintain a safe treatment environment during observations for 2 of 2 days. Findings include: A revised April 2018 policy titled, "PHYSICAL ENVIRONMENT" was provided by the Administrator on 4/8/2021 at 11:23 a.m. The policy indicated, but was not limited to, "1. The dialysis facility will be ... maintained to provide dialysis patients, teammates ... a safe, functional ... treatment environment." An observation of dim lighting noted throughout patient treatment area on 4/5/2021 and 4/7/2021 while patients were receiving dialysis treatment. During an interview on 4/7/2021 at 8:55 a.m., PCT (patient care technician) I stated, "this facility is so dark. It's not like the others. I wear these [pointed to goggles] instead of a shield so there isn't that weird glare you have to look around to do an access. It's hard to see."	V 0401	**V 401** 100% of teammates will be in-serviced on Policy 8-*04-01 "Physical Environment"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed with emphasis on: 1. The dialysis facility will be…maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. The Facility Administrator (FA) will maintain lighting in the treatment area at a level to allow visualization of patients to detect potential complications and teammates to perform duties. The FA or designee will conduct observational audits daily x 1 week, then 3 x week x 2 weeks, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with monthly audits x 3 months. The FA will review audit results with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 4/30/21	04/30/2021
V 0402 Bldg. 00	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are			

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	152682	A. BUILDING 00 B. WING	04/08/2021

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	furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. Based on observation, record review, and interview, the facility failed to ensure medications were secured and/or under supervision of a licensed nurse for 3 of 3 medication preparation area observations. Findings include: 1. A revised April 2021 policy titled, "MEDICATION POLICY" was provided by the Administrator on 4/6/2021 at 12:35 p.m. The policy indicated, but was not limited to, "11. All refrigerated medications, for example Epogen and vaccines are to be locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations. Non-refrigerated medications are to be stored in cabinet(s) and locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations." 2. During an observation on 4/5/2021 at 8:50 a.m., all cabinets and drawers in the medication preparation area, as well as the medication refrigerator were unlocked and accessible. Boxes containing Hepatitis B vaccine, Epogen, Venofer 50 mg, Venofer 100 mg, and Hecterol vials, as well as unidentified medication capsules in a medication cup, were observed sitting on the countertop in the medication preparation area. RN (Registered Nurse) C was the only licensed nurse in the treatment area and he/she was providing patient care in the treatment area, leaving the medications and medication area unsupervised. 3. During an observation on 4/5/2021 at 11:09 a.m., open vials of Epogen and Hecterol were observed	V 0402	**V 402** 100% of licensed teammates will be in-serviced on *Policy 1-06-01 "Medication Policy"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) All refrigerated medications, for example Epogen and vaccines are to be locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations. Non-refrigerated medications are to be stored in cabinet(s) and locked at the close of each business day or if not under supervision by the licensed teammate or per state regulations. The Facility Administrator or designee will conduct observational audits daily x 1 week, then 3 times a week for 2 weeks, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with the monthly medication audit. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction.	04/30/2021

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	sitting on the countertop in the the medication preparation area. 4. During an observation on 4/5/2021 at 1:59 p.m., boxes containing new vials of Venofer 50 mg, Venofer 100 mg, and Hectorol were observed sitting on the countertop in the medication preparation area. 5. During an interview on 4/5/2021 at 8:50 a.m., RN C stated that all cabinets in the medication preparation area and refrigerator get unlocked and remain unlocked until the end of the shift.		Completion Date: 4/30/21	
V 0406 Bldg. 00	494.60(c)(3) PE-ACCOMMODATE PT PRIVACY The dialysis facility must make accommodations to provide for patient privacy when patients are examined or treated and body exposure is required. Based on observation, record review, and interview, the facility failed to provide privacy during dialysis treatment and disconnection of a CVC (central venous catheter) site for 1 of 2 patient observations with a CVC. (Patient 2) Finding include: A 09/2008 policy titled Patient's Rights was provided by the Administrator on 4/7/2021 at 10:40 a.m. The policy indicated, but was not limited to, "To be treated with (i) respect, dignity, ... 4. 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 ... " During an observation on 4/5/2021 between 10:00 a.m. and 2:30 p.m. patient 2's shirt was pulled up	V 0406	**V 406** 100% of clinical teammates will be in-serviced on Policy *3-01-07A "Patient's Rights"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) To be treated with (i) respect, dignity,…2) The right to privacy and confidentially in all aspects of treatment. 3) The dialysis facility will make accommodations to provide for patient privacy when patients are examined or body exposure is required…The Facility Administrator (FA) or designee will	05/07/2021

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	and 3/4 of his/her abdomen and chest were exposed to other patients. During patient 2's CVC (thin tube into a large vein) disconnection, PCT (patient care technician) G pulled patient 2's shirt up higher exposing the patient's chest and access cite. Once PCT G was done with disconnecting, PCT G left the station area failing to pull down the patient's shirt leaving him/her exposed to other patients. During an observation on 4/7/2021 at 1:27 p.m. patient 2's shirt was pulled up and 3/4 of his/her abdomen and chest were exposed to other patients during dialysis treatment. Patient 2's CVC access site was covered by the shirt. At that time, PCT F was interviewed and stated they have to pull the shirt up to access his/her CVC site.		conduct observational audits daily x 1 week, then 3 times a week x 2 weeks, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with observational audits monthly x 3 months. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
V 0454 Bldg. 00	494.70(a)(3) PR-PRIVACY & CONFIDENTIALITY-TREATMENT The patient has the right to- (3) Privacy and confidentiality in all aspects of treatment; Based on observation, record review, and interview, the facility violated the patient's right to privacy during dialysis treatment and during disconnection of a CVC (central venous catheter) site for 2 of 2 patient observations. (Patient 2) Finding include: A 09/2016 policy titled Patient's Rights was provided by the Administrator on 4/7/2021 at 10:40 a.m. The policy indicated, but was not limited to, "To be treated with (i) respect, dignity, ... 4. The right to privacy and confidentiality in all aspects of treatment. The dialysis facility will make accommodations to provide for patient	V 0454	**V454** 100% of clinical teammates will be in-serviced on Policy *3-01-07A "Patient's Rights"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) To be treated with (i) respect, dignity…2) The right to privacy and confidentially in all aspects of treatment. 3) The	05/07/2021

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	privacy when patients are examined or body exposure is required ... " During an observation on 4/5/2021 between 10:00 a.m. and 2:30 p.m. patient 2's shirt was pulled up and 3/4 of his/her abdomen and chest were exposed to other patients for the duration of the treatment. During patient 2's CVC (thin tube into a large vein) disconnection, PCT (patient care technician) G pulled patient 2's shirt up higher exposing the patient's chest and access cite. Once PCT G was done with disconnecting the patient from the dialysis machine, PCT G left the station area failing to pull down patient 2's shirt leaving his/her abdomen and chest exposed to other patients. During an observation on 4/7/2021 at 1:27 p.m. patient 2's shirt was pulled up and 3/4 of his/her abdomen and chest were exposed to other patients during dialysis treatment. Patient 2's CVC access site was covered by the shirt. At that time, PCT F was interviewed and stated they have to pull the shirt up to access his/her CVC site. During exit conference on 4/8/2021 at 11:50 a.m. the Administrator was unable to provide any additional information or comments.		dialysis facility will make accommodations to provide for patient privacy when patients are examined or body exposure is required…The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week, then 3 times a week x 2 weeks, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with observational audits monthly x 3 months. The FA will review audit findings with the Medical Director during monthly QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	
V 0455 Bldg. 00	494.70(a)(4) PR-PRIVACY & CONFIDENTIALITY-RECORDS The patient has the right to- (4) Privacy and confidentiality in personal medical records; Based on observation, record review, and interview, the facility failed to protect patient health information records from view of visitors and patients for 10 of 10 patients, which had the	V 0455	**V 455** 100% of teammates will be in-serviced on Policy *3-01-07A "Patients Right's" and Policy*	04/30/2021

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	potential to affect all patients. (Patients 3, 4, 16, 18, 19, 20, 21, 22, 23, 24); and failed to dispose of protected health information appropriately for 3 of 3 observations. (PCT F, PCT G, PCT I) Findings include: 1. A revised 09/2016 policy titled Patient Rights was provided by the Administrator on 4/7/2021 at 10:40 a.m. The policy indicated, but was not limited to, "As a DaVita patient I am entitled... To know my medical record and the information contained will be considered private and confidential ..." 2. A revised 09/2020 policy titled Disposal of Records or Materials Containing Protected Health Information was provided by the Administrator on 4/6/2021 at 12:03 p.m. The policy indicated, but was not limited to, " ... disposing of Protected Health Information (PHI) in a manner that is private and secure in accordance with applicable privacy laws, regulations and requirements, including but not limited to HIPAA ... a. With respect to paper copies of PHI: 1. Cross Shredding all documents containing PHI ... PHI must not be discarded in trashcans or recycle bins ... " 3. During an observation of the facility on 4/5/2021 between 8:50 a.m. to 2:30 p.m. patients 3, 4, 16, 18, 19, 20, 21, 22, 23, and 24's prescription treatment sheet orders were spread out, face up on a counter between two dialysis stations while patients and one visitor were present. The documents contained the patients' names, dates of birth, ID numbers, and physicians orders. The facility failed to protect patient health information from casual access. 4. During an observation on 4/5/2021 at 2:21 p.m.,		*3-05-58 "Disposal of Records or Materials Containing Protected Health Information" beginning* 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) As a Davita patient I am entitled…To know my medical records and the information contained will be considered private and confidential and only released in compliance with state and federal law. 2) …disposing of Protected Health Information (PHI) in a manner that is private and secure in accordance with applicable privacy Laws, regulations and requirements, including but not limited to HIPAA. 3) …With respect to paper copies of PHI: Cross Shredding all documented containing PHI…PHI must not be discarded in trashcans or recycle bins…The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week, then 3 times a week for 1 week, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with observational audits monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing	

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	PCT F discarded patient 8's dialysis prescription was observed in the biohazard container. 5. During an observation on 4/5/2021 at 2:41 p.m., PCT G discarded patient 2's dialysis prescription was observed in the biohazard container. 6. During an observation on 4/7/2021 at 7:58 a.m., PCT I placed patient 16's dialysis prescription in a cardboard box labeled "keep," on the treatment floor, face up with protected health information visible. 7. During an interview on 4/5/2021 at 9:00 a.m. RN (Registered Nurse) C stated the prescription sheets that were laid out on the counter were for Wednesday's treatments. 8. During an interview on 4/5/2021 at 3:00 p.m. the Administrator stated that PHI was kept face up on the counters and that PHI was thrown into the biohazard trash. The Administrator stated the biohazard trash gets incinerated and did not see it as an issue.		compliance with the Plan of Correction. Completion Date: 4/30/21	
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 a licensed nurse was notified that BFR's (blood flow rate) were maintained throughout dialysis treatments for 3 of 5 records reviewed (Patients 1, 2, 3); failed to ensure a licensed nurse and/or physician was informed that patient blood lines were reversed for 1 of 5	V 0544	**V 544** 100% of clinical teammates will be in-serviced on Policy 1-03-08 "*Pre-Intra-Post Treatment Data Collection, Monitoring, Nursing Assessment",* Policy *1-04-05 "Blood Flow Problems"* Job	05/07/2021

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	records reviewed (Patient 1); and failed to inform the licensed nurse was notified of abnormal findings for 2 of 5 records reviewed. (Patient 1, 3) Findings include: 1. A revised April 2021 policy titled, "PRE-INTRA-POST TREATMENT DATA COLLECTION, MONITORING AND NURSING ASSESSMENT" was provided by the Administrator on 4/6/2021 at 10:09 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. 11. Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately (refer to 'Abnormal Findings' section in this policy. The licensed nurse will use his/her clinical judgement based on individual patient needs to determine if any clinical interventions are necessary. ... Unless other abnormal parameters are established by the facility Governing Body and documented in the Governing Body Meeting minutes, the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record. ... Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being immediately to the licensed nurse at any time. ... Pre/Intra/Post Patient Reports/Complaints and/or teammate observations of: ... Cramping..." 3. A revised October 2020 policy titled, Blood Flow Problems was provided by the Administrator on 4/6/2021 at 12:03 p.m. The policy indicated, but was not limited to, "If blood flow problem remains		Description *"Patient Care Technician III Chronic", and* Job Description *"Registered Nurse III Chronic"* beginning *4/22/21.* Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) If the dialysis prescription is not being met (including dialysis flow rate1 or change to/inability to obtain prescribed blood flow rate) the reason will be documented and licensed nurse informed. 2) Abnormal findings or findings outside of any patient specific physician ordered parameters will be reported to the licensed nurse immediately (refer to "Abnormal Findings" section in this policy). The licensed nurse will use his/her clinical judgment based on individual patient needs to determine if any clinical interventions are necessary. 4) Unless other abnormal parameters are established by the facility Governing Body and documented in the Governing Body Meeting minutes, the following are considered abnormal findings and should be reported to the licensed nurse and documented in the patient's medical record…Members of the patient care team should report ANY changes in patient conditions or concerns of patient well-being	

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	unresolved, notify licensed nurse ... Notify nephrologist for further evaluation and/or interventions." 4. A March 2014 job description for title "Patient Care Technician III Chronic" was provided by the Administrator on 4/6/2021 at 1:30 p.m. The policy indicated, but was not limited to, "ESSENTIAL DUTIES & RESPONSIBILITIES ... Collects patient data, including but not limited to: ... documents patient observations and seeks guidance when levels are out of normal range for ESRD patients, reports patient parameters to registered nurse as needed." 5. A March 2014 job description for title "Registered Nurse III Chronic" was provided by the Administrator on 4/6/2021 at 1:30 p.m. The policy indicated, but was not limited to, "ESSENTIAL DUTIES & RESPONSIBILITIES ... Analyzes patient assessments ... and, when concerns are noted, brings issues to the attention of the physician." 6. A record review for Patient 1 indicated a prescribed BFR of 400 ml/min. The treatment record for 3/24/2021 noted a BFR of 350 ml/min at 2:00 p.m. (PCT F), 2:30 p.m. (PCT E), and 3:00 p.m. (PCT G). RN C noted the BFR of 350 ml/min at 3:30 p.m. The treatment record for 4/2/2021 indicated the BFR as N/A (not applicable) was noted by the Administrator at 2:01 p.m. The BFR was then noted as 350 ml/min at 2:31 p.m. (PCT E), 3:01 p.m. (PCT G), 3:31 p.m. (PCT E), 4:01 p.m. (PCT E), 4:31 p.m. (PCT E) and was not noted by a licensed nurse. 7. A record review for Patient 3 indicated a prescribed BFR of 400 ml/min. The treatment record for 3/15/2021 noted a BFR of 150 ml/min at		immediately to the licensed nurse at any time…5) Pre/Intra/Post Patient Reports/Complaints and/or teammate observations of: …Cramping…6) If blood flow problem remains unresolved, notify licensed nurse. 6) Patient Care Technician III Chronic – ESSENTIAL DUTIES & RESPONSIBILITIES…Collects patient data, including but not limited to: …documents patient observations and seeks guidance when levels are out of normal range for ESRD patients, reports patient parameters to registered nurse as needed. 7) Registered Nurse III Chronic: ESSENTIAL DURITES & RESPOSIBILITIES…Analyzes patient assessments…and, when concerns are noted, brings issues to the attention of the physician. The Facility Administrator (FA) or designee will conduct audits on 100% post treatment records daily x 1 week, then 50% of post treatment records weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with 10% of post treatment records audited monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction.	

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	5:39 a.m. (PCT G) and a BFR of 200 ml/min at 5:40 a.m. (noted by box was blank), and was not noted by a licensed nurse. The treatment record for 3/26/2021 noted the BFR as 300 ml/min at 7:31 a.m. (PCT E), 350 ml/min at 8:01 a.m. (PCT G), and was noted as 350 ml/min by RN C at 8:23 a.m. 8. A review of Patient 1's treatment record for 3/19/2021 at 3:05 p.m., indicated RN D reversed the dialysis blood lines due to high AP (arterial pressure). A treatment record for 3/22/2021 at 2:30 p.m., indicated PCT G reversed the dialysis blood lines due to high AP. Patient 1 was not assessed by a licensed nurse until 3:03 p.m., by RN C. The patient's record did not include notification of the physician for blood lines needing reversed a second time. 9. A review of Patient 1's treatment record for 3/19/2021 indicated at 4:51 p.m., PCT G noted the patient complained of cramping, ultrafiltration was off, and PCT G gave 100 ml of normal saline. The treatment record does not indicate notification of abnormal findings to the licensed nurse, by PCT G.10. A record review for patient 2 indicated a prescribed BFR of 350 ml/min. The treatment record for 3/19/2021 indicated a BFR of 330 ml/min at 11:31 a.m. (PCT E), 12:01 a.m. (PCT E), 12:31 a.m. (PCT E), 1:02 a.m. (PCT E), 1:31 p.m. (RN D), 2:01 p.m. (PCT F), and 2:16 p.m. (PCT F). Review of the intradialytic treatment sheet dated 3/19/2021 evidenced the BFR was lowered to 300 without a documented reason. 11. A record review for patient 2 indicated a prescribed BFR of 350 ml/min. The treatment record for 4/2/2021 indicated a BFR of 300 ml/min at the beginning of treatment 10:24 a.m. (PCT G)., 10:31 a.m. (PCT G), 11:01 a.m. (PCT F), 11:31 a.m.. (RN C), 12:01 p.m. (PCT G), 12:31 p.m. (PCT G),		Completion Date 5/7/21	

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EAGLES DIALYSIS	5301 PEARL DR EVANSVILLE, IN 47712

(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
	1:01 p.m. (PCT G), 1:31 p.m. (PCT E), 2:01 p.m. (PCT G), and 2:27 p.m. (PCT G). The BFR ran at 300 ml/min the entire treatment indicating a high AP of -210 at 10:24 a.m. The treatment record did not indicate the physician was notified the BFR was not met a second time. 12. During an interview on 4/6/2021 at 2:12 p.m., the Medical Director was asked if the staff should notify the physician if patient lines are reversed. The Medical Director stated he/she would expect to be contacted if lines were reversed more than once as it would indicate a need to look further into it. The Medical Director indicated a physician would not be notified if the BFR was not met once, but would expect to be notified if a trend was occurring.			
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 observation, record review, and interview, the facility failed to follow their own policy recommendations for vascular access clamps for 1 of 4 observations of discontinuing an AV/fistula.(Patient 13); and to ensure hemostasis occurred after removing the venous needle and before removing the arterial needle for 4 of 4 observations of discontinuing an AV/fistula. (Patient 3, 13, 16, 17) Findings include:	V 0715	**V715** 100% of clinical teammates will be in-serviced on Policy *1-04-08 "Utilizing Vascular Access Clamps" and 1-04-01B "Post Dialysis Vascular Access Care: Fistula/Graft Using Safety Fistula Needles"* beginning 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be to be instructed using surveyor	05/07/2021

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	152682	A. BUILDING 00 B. WING	04/08/2021

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	1. A revised April 2019 policy titled, "UTILIZING VASCULAR ACCESS CLAMPS" was provided by the Administrator on 4/7/2021 at 10:40 a.m. The policy indicated, but was not limited to, "... it is recommended that only one (1) clamp is used at a time ..." 2. A 09/2020 article titled Care of Needling Sites Post Hemodialysis for Fistulas & Grafts (Hemostasis) indicated, but was not limited to, "Hemostasis is best achieved by removing the needles one at a time. Start by removing the venous needle. If the patient is holding his/her own sites, wait until after the venous needle site has clotted (10-15 minutes) before removing the arterial needle." 3. During an observation of discontinuation of dialysis for a fistula/graft for Patient 13, PCT I removed one vascular access and applied a vascular access clamp, immediately removed the second vascular access and applied a second vascular access clamp. 4. During an interview on 4/7/2021 at 9:55 a.m., the Administrator stated, "You shouldn't clamp both at the same time. Clamps should be one at a time."5. During an observation on 4/7/2021 at 7:24 a.m. observed PCT F remove patient 17's venous needle from the right access site. PCT F applied gauze with tape and taped a clamp down to the venous site. PCT F then immediately removed patient 17's arterial needle, applied a gauze dressing with tape and proceeded to stay with patient to hold pressure to the arterial site. PCT F failed to ensure hemostasis (stop bleeding) occurred at the venous site prior to removing the arterial needle. 6. During an observation on 4/7/2021 at 7:50 a.m.		observations as examples with emphasis on, but not limited to the following: 1) …it is recommended that only one (1) clamp is used at a time and should not be left on longer than 20 minutes. 2) Hold site for at least 5-10 minutes…3) Once bleeding has stopped…Apply band-aid over cannulation site. 4) Repeat steps…for other needle. The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week, then 3 x week x 1 week, and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date: 5/7/21	

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	observed RN C remove patient 16's venous needle from the left access site. RN C applied a gauze dressing and instructed patient 16 to apply pressure to the site. RN C immediately removed patient 16's arterial needle from the left access site, applied a gauze dressing, and instructed patient 16 to apply pressure to the site. RN C then left the station. Observed small amount of blood leaking from venous site. Interviewed patient 16 at that time, and asked if that was normal to remove both needles at the same time to which he/she stated "yes, and sometimes I bleed." Patient 16 continued to hold pressure on both venous and arterial access sites. RN C failed to ensure hemostasis occurred at the venous site prior to removing the arterial needle. 7. During an observation on 4/7/2021 at 8:40 a.m. observed PCT G remove patient 3's venous needle from the left access site. PCT G applied a gauze dressing and placed a white clamp taped down to patient 3's left access site for pressure. PCT G immediately removed patient 3's arterial needle from the left access site, applied a gauze dressing and instructed patient 3 to apply pressure. At that time, PCT G indicated patient 3 bleeds from the access site at times. PCT G failed to ensure hemostasis occurred at the venous site prior to removing the arterial needle.			
V 0727 Bldg. 00	494.170(a) MR-PROTECT PT RECORDS FM LOSS/CONFIDENTIAL The dialysis facility must- (1)Safeguard patient records against loss, destruction, or unauthorized use; and (2) Keep confidential all information contained in the patient's record, except when release is authorized pursuant to one of the following: (i) The transfer of the patient to another			

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	facility. (ii) Certain exceptions provided for in the law. (iii) Provisions allowed under third party payment contracts. (iv) Approval by the patient. (v) Inspection by authorized agents of the Secretary, as required for the administration of the dialysis program. Based on observation, record review, and interview, the facility failed to protect patient health information records from view of visitors and patients for 1 of 1 survey days. (Patients 3, 4, 16, 18, 19, 20, 21, 22, 23, 24) Findings include: A revised 09/2016 policy titled Patient Rights was provided by the Administrator on 4/7/2021 at 10:40 a.m. The policy indicated, but was not limited to, "As a DaVita patient I am entitled... To know my medical record and the information contained will be considered private and confidential ..." During an observation of the facility on 4/5/2021 between 8:50 a.m. to 2:30 p.m. patients 3, 4, 16, 18, 19, 20, 21, 22, 23, and 24's prescription treatment sheet orders were spread out, face up on a counter between two dialysis stations while patients and one visitor were present. The facility failed to protect patient health information from casual access. During an interview on 4/5/2021 at 9:00 a.m. RN C stated the prescription sheets that were laid out on the counter were for Wednesday's treatments.	V 0727	**V 727** 100% of teammates will be in-serviced on Policy *3-01-07A "Patients Right's" and Policy 3-05-58 "Disposal of Records or Materials Containing Protected Health Information" beginning* 4/22/21. Verification of attendance will be evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) As a Davita patient I am entitled…To know my medical records and the information contained will be considered private and confidential and only released in compliance with state and federal law. 2) …disposing of Protected Health Information (PHI) in a manner that is private and secure in accordance with applicable privacy Laws, regulations and requirements, including but not limited to HIPAA. 3) …With respect to paper copies of PHI: Cross Shredding all documented containing PHI…PHI must not be discarded in trashcans or recycle	05/07/2021

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			bins…The Facility Administrator (FA) or designee will conduct observational audits daily x 1 week, then 3 x week x 1 week and then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. The FA will review audit findings with the Medical Director during QAPI, known as Facility Health Meeting. The FA is responsible for ongoing compliance with the Plan of Correction. Completion Date 5/7/21	