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	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
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: 04/22/2024 to 04/25/2024 Active Census: 46 At this Emergency Preparedness survey, Eagles Dialysis was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR Completed on 05/02/2024 by A4	E 0000		
V 0000 Bldg. 00	This visit was for a CORE Federal recertification survey of an ESRD provider. Survey dates: 04/22/2024-04/25/2024 Census by Service Type: In-Center Hemodialysis: 46 Home Hemodialysis: 0 Home Peritoneal dialysis: 0 Total Active Census: 46 Isolation Room: 1	V 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Thomas	Facility Administrator	05/10/2024

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

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V 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 dialysis facility failed to follow facility policy regarding labeling bleach solution containers and preparing bleach solutions for 1 of 4 observation days. Findings include: 1. A revised policy dated 10/2023, titled, "Preparation of One to Ten Bleach Solution," indicated materials required to prepare the bleach solution would include a plastic 1000 milliliter graduated cylinder calibrated in 10 milliliter increments. The policy indicated the bleach solution would be labeled with one to ten bleach solution and have a container with a lid, the container would be labeled, and the solution was to be covered with a lid when the solution was not in use. 2. A revised policy dated 10/2023, titled, "Preparation of One to One Hundred Bleach Solution," indicated materials required to prepare the bleach solution would include a plastic 1000 milliliter graduated cylinder calibrated in 10 milliliter increments. The bleach solution would be labeled with one to one hundred bleach solution and have a container with a lid, the container would be labeled, and the solution was to be covered with a lid when the solution was not in use. 3. During an observation on 04/22/2024, beginning	V 0111	The Facility Administrator will in-service all clinical teammates on Policy 1-05-08A "Preparation Of One to Ten (1:10) Bleach Solution" and Policy 1-05-08B "Preparation Of One to One Hundred (1:100) Bleach Solution" beginning 4/23/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, with emphasis on, but not limited to the following: 1) One to Ten (1:10) bleach solution- Materials required: …Plastic 1000 ml (1 liter) graduated cylinder calibrated in 10 ml increments, dedicated for bleach mixing only; Container with lid; Label with one to ten (1:10) bleach solution and permanent HazCom label…2) With indelible marking pen and label, label container with expiration date, time and initials. 3) When the solution is not being used, place a lid on the bleach solution container. 4) One to One Hundred (1:100) bleach solution - Materials required: …Plastic 1000 ml (1 liter) graduated cylinder calibrated in 10 ml increments…5) With indelible marking pen and	05/24/2024

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	at 11:50 AM, a non-labeled container with fluid next to the sink labeled clean at the medication preparation area included a separate sign near the container that said bleach 1:100, and the lid was off of the container, no staff was using the bleach solution during observation. A bleach solution container titled 1:10 next to a sink labeled dirty at the medication preparation area included a separate sign near the container that said bleach 1:100. A bleach solution container titled 1:100 next to a sink labeled dirty at the medication preparation area included a separate sign near the container that said bleach 1:10. A bleach solution container titled 1:10 next to a sink labeled clean in the patient care area included a separate sign near the container that said bleach 1:100. During an observation on 04/22/2024, at 1:15 PM, the non-labeled container's lid with fluid, next to the sink labeled clean at the medication preparation area that included a separate sign near the container that said bleach 1:100, remained off and was not in use by any staff. During an observation on 04/22/2024, at 12:00 PM, PCT (Patient Care Technician) 1 showed the calibrated cylinder used to make the bleach solution that started at 100 milliliter increments and did not show calibration at 10 milliliter increments. The observation failed to evidence the bleach solution was made correctly, labeled correctly, and had a lid covered per the facility's policy. 4. During an interview on 04/22/2024, at 12:00 PM, PCT 1 indicated the non-labeled container with fluid next to a sink labeled clean at the medication preparation area was bleach solution and the lid should be on the container. PCT 1 indicated the		label, label container with expiration date, time and initials. 6) When the solution is not being used, place a lid on the bleach solution container). 7) Medical waste is contained separately from other noninfectious waste generated in the facility. 8) Sharps are discarded at the point of origin into a sharps container. The Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	

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	containers with bleach solution next to the a sink labeled dirty at the medication preparation area and the plastic signs were mixed up and the container on the right should contain 1:100 and the container to the left should contain 1:10 but the separate plastic signs were incorrectly placed, and the staff should have gone by the separate plastic sign not the container bleach solution information. PCT 1 indicated when she made the bleach solution 1:100 she would use 990 milliliters of water and 10 milliliters of bleach but would guess at the 10 milliliter level due to the cylinder calibration started at 100 milliliters. 5. During an interview on 04/22/024, at 4:24 PM, the Facility Administrator indicated the PCT should not guess at the milliliters of bleach for the bleach solution, the containers would need to be labeled correctly and not use a separate sign so there was not confusion with the staff on which bleach solution was in each container. 6. During an observation on 04/22/24 at 1:00 PM, PCT 3 provided care to Patient #7 at Station #9. She wheeled a sharp container cart into Station #9's area, where she found a used syringe from Patient #2 lying outside of the sharps container. The agency failed to provide a sanitary environment to prevent the spread of infection. During an interview on 04/22/2024 at 1:00 PM, PCT 3 indicated that used syringes should be placed in the sharps container, not on the wheeled cart.			
V 0112 Bldg. 00	494.30(a) IC-CDC MMWR 2001 The facility must demonstrate that it follows standard infection control precautions by implementing- (1)(i) The recommendations (with the			

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	exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html. The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.			
	Based on observation, record review, and interview, the facility failed to maintain infection control precautions for 1 of 3 observation days on the treatment floor. (PCT 3) Findings include: A policy titled "Infection Control for Dialysis Facilities" was provided by the Manager of	V 0112	The Facility Administrator will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” and Policy beginning 4/24/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor	05/24/2024

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	Clinical Services (MCS) on 04/23/2024. The policy indicated that clean areas should be separated from contaminated items and surfaces. During an observation on 04/22/2024 at 2 PM, a soiled glove was left in a designated clean sink across from station 9. The trash bin was touching the clean sink across from station 9. During an interview at that time, Patient Care Technician (PCT) 3 was asked why dirty items were touching the clean sink. PCT 3 stated she was unaware that the dirty items were touching the designated clean items. PCT 3 removed the dirty items from the clean area. The facility staff failed to separate dirty items from designated clean areas properly. During an interview on 04/23/2024, the Facility Administrator (FA) stated no dirty items should touch designated clean surface areas.		observations as examples, with emphasis on, but not limited to the following: 1) Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. The Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Wear disposable gloves when caring for the			

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	patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. Based on observation, record review, and interview, the facility failed to ensure gloves were worn and changed appropriately, and hand hygiene was performed effectively for 3 of 3 patient care technician (PCT) observations. (PCTs 1, 2, 3) Findings include: 1. A policy titled "Infection Control For Dialysis Facilities" was provided by the Manager of Clinical Services (MCS) on 04/23/2024. The policy indicated that staff members are required to perform hand hygiene before and immediately after gloving, and before medication preparation. The policy indicated that clean areas should be separated from dirty supplies and equipment. 2. During an observation on 04/23/2024 at 9:14 AM, Patient Care Technician (PCT) 3 failed to remove her gloves and perform hand hygiene after disconnecting bloodlines for Patient #16 and before touching Patient #16's blanket, bag, phone, coat, and wheelchair. 3. During an interview on 04/24/2024 at 4:00 PM, the Facility Administrator (FA) stated staff members are required to perform hand hygiene before and immediately after gloving, and before medication preparation.4. During an observation on 04/22/2024 at 11:15 AM, Patient Care Technician (PCT) 2 placed dirty gloves directly on Patient #1's chair side table. PCT 2 failed to change gloves or perform hand hygiene when going from a dirty to clean area. PCT 2 then accessed Patient #1's CVC hubs. PCT 2 failed to	V 0113	The Facility Administrator will in-service all clinical teammates on Policy 1-05-01 “Infection Control For Dialysis Facilities” and Policy 1-06-01 Medication Policy beginning 4/24/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, with emphasis on, but not limited to the following: 1) HAND HYGEINE - All teammates, Physicians and Non -Physician (NPP) will perform hand hygiene: …prior to gloving and immediately after removal of gloves; after contamination with blood or other infectious material, d. after patient and dialysis delivery system contact,… between patients even if the contact is casual, g. before touching clean areas such as supplies, supply cart and chairside keyboard/mouse. 2) An aseptic environment and aseptic technique is used when preparing medications. 3) Careful attention to proper hand washing is performed at this time. The Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly	05/24/2024

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	properly dispose of contaminated gloves; perform glove changes with hand hygiene after contact with the patient and when going from a dirty to clean surface. The facility failed to maintain infection control while caring for Patient #1. 5. During an observation on 04/22/2024 at 12:05 PM,CT 1 failed to change gloves or perform hand hygiene when going from a dirty to clean area. PCT 1 then accessed Patient #1's CVC hubs. PCT 1 then accessed Patient #1s CVC hubs. PCT 1 failed to change gloves and hand hygiene when moving from a dirty task to a clean task. The PCT failed to maintain infection control during the care of Patient #2. During an interview on 04/22/2024 at 12:20 PM, PCT 1 indicated she was unaware that gloves were not changed after performing the site dressing change or before starting the next procedure. 6. During an observation on 04/22/24 at 1:00 PM, PCT 3 failed to change gloves and hand hygiene before assisting patient # 7 with personal items. No glove change or hand hygiene was performed. The facility failed to maintain infection control. 7. During an observation on 04/23/24 at 9:45 AM, PCT 3 used dirty gloves to access Patient #11's graft site. PCT 3 failed to change gloves and hand hygiene when moving from dirty to clean tasks, before or after touching Patient 11, and after contacting dirty surfaces. The facility failed to maintain infection control. 8. During an observation on 04/24/2024 at 10:20 AM, RN 1 did not perform hand hygiene before withdrawing medication from the vial and before gloving and did not use an alcohol prep pad to		during the internal infection control audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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	clean the hub (used to administer medication and fluids into the intravenous line) of the dialysis machine before attaching a syringe to administer Patient #18's intravenous medication. The agency failed to maintain infection control during patient care. 9. During an observation on 04/24/2024 at 10:30 AM, RN 1 did not clean the surface of the medication prep area before prepping medication, no hand hygiene was performed before gloving, and no alcohol prep pad was used to clean the hub on the dialysis machine before attaching the syringe to the administered Patient #19's intravenous medication. The agency failed to maintain infection control during patient care.			
V 0184 Bldg. 00	494.40(a) ENVIRONMENT-SECURE & RESTRICTED 8 Environment: secure & restricted The water purification and storage system should be located in a secure area that is readily accessible to authorized users. The location should be chosen with a view to minimizing the length and complexity of the distribution system. Access to the purification system should be restricted to those individuals responsible for monitoring and maintenance of the system. Based on observation, record review, and interview, the facility staff failed to secure the entrance to the water purification and storage system and dialysis treatment area from unauthorized persons for 1 of 1 facility observations. Findings include: 1. A policy titled "Access Control Systems" was provided by the Manager of Clinical Services on	V 0184	V184 5/24/24 The Facility Administrator will in-service all clinical teammates on Policy 8-04-01 “Physical Environment” and Policy 9-01-07 “Access Control Systems” beginning 4/25/24. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, with	05/24/2024

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	04/23/2024. The policy indicated that staff are to detect and control potential unauthorized access that may affect the facility's security. 2. A policy titled "Physical Environment" was provided by the Manager of Clinical Services on 04/23/2024. The policy indicated the facility will provide a safe and secure environment for patients and staff. 3. During an observation on 04/22/2024 at 10:10 AM, evidenced an unlocked back door where patient dialysis supplies were kept that led to an unsecured treatment floor area. At that time, Registered Nurse (RN) 1 was asked why the door was left unlocked. RN 1 stated there may have been a delivery but was not sure. RN 1 did not lock the door at that time. The agency failed to ensure staff controlled potential unauthorized access to the water room/storage area and dialysis treatment area. 4. During an observation on 04/22/2024 at 1:00 PM, evidence of an unlocked back door where patient dialysis supplies were kept that led to an unsecured treatment floor area. At that time, the BIO/MED personnel stated he was not sure why it was left unlocked. The agency failed to ensure staff controlled potential unauthorized access to the water room/storage area and dialysis treatment area.		emphasis on, but not limited to the following: 1) The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment. 2) Access to patient treatment areas, water treatment systems, supply storage and dialysis equipment is restricted to authorized personnel only. 3) This Access Control System policy is to be implemented…to help deter, detect, and control potential physical security and safety risks that may occur to Davita's environments, including unauthorized access…that may affect the location's physical security or cause business disruption. The Facility Administrator or designee secured the back door on 4/22/24 when made aware that the door was not locked. Going forward, the Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance	

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			Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	
V 0250 Bldg. 00	494.40(a) DIALYS PROPORT-MONITOR PH/CONDUCTIVITY 5.6 Dialysate proportioning: monitor pH/conductivity It is necessary for the operator to follow the manufacturer's instructions regarding dialysate conductivity and to measure approximate pH with an independent method before starting the treatment of the next patient. Based on observation, record review, and interview, the agency failed to follow manufacturer instructions to obtain an accurate pH level on 2 of 3 staff observed pH test samples. (RN1, PCT 3) Findings include: 1. A document titled "E-Z Check 6.8 - 8.5 pH Test Strip Instructions for Use" indicated dipping the test strip into the solution being tested and remove; after 10 seconds, compare the color on the test strip to the chart on the test strip bottle to determine the result of the Bicarbonate citrate	V 0250	V250 The manufacturer changed the instructions for use for testing pH of Citric Acid Base dialysate. Davita revised the policy for use of the “RPC E-Z CHEK K100-0117CK 6.8-8.5 Test Strips for testing pH of Citric Acid Base Dialysate” in accordance with manufacturer guideline 0224. The Facility Administrator immediately removed the expired bottle of PH Test strips from use in the facility. The Facility Administrator will in-service all clinical teammates	05/24/2024

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	dialysate. After 15 seconds from the test strip being removed from the solution, compare the color to the chart on the test strip bottle for the results of the Bicarbonate Concentrate. 2. During an observation on 04/23/2024 at 9:45 AM, Patient Care Technician (PCT) 3 dipped the pH test strip into the solution and read the result immediately. The PCT 3 did not follow the manufacturer's instructions on the required 10-second wait time before reading the Bicarbonate citrate dialysate or the 15-second wait time before reading the Bicarbonate Concentrate test results. The facility failed to obtain an accurate pH level test result for Patient # 11. 3. During an interview on 04/23/2024, at 1:24 PM, the Manager of Clinical Services indicated that team members are trained to collect pH test results accurately and are instructed to wait the required time before reading them. 4. During an observation on 04/22/2024 at 12:16 PM, Registered Nurse (RN) 1 performed a pH test (measures acidity/alkalinity of a substance). RN 1 dipped the test strip into the solution, shook off the excess, and immediately compared it to the color scale on the pH bottle for a result. RN 1 stated the green color was hard to match against the color scale. RN 1 repeated the test similarly and could not get an accurate color match. RN 1 failed to follow the manufacturer's instructions on the bottle, which indicated waiting and comparing against the color scale at 10 seconds and again at 15 seconds for a result. 5. During an interview on 04/22/2024 at 12:30 PM, the BioMed personnel was asked if RN 1 was supposed to follow the instructions on the pH bottle regarding the wait time, to which he replied, "Yes."		on the revised policy 1-21-09 "Testing pH of Citric Acid Base Dialysate Using RPC E-Z Chek K100-0117CT 6.8-8.5 Test Strips" beginning 4/25/24. Verification of attendance will be evidenced by an inservice signature sheet. Teammates will be educated using surveyor observations as examples, with emphasis on, but not limited to the following: 1) Obtain dialysate sample by using a disposable collection cup, then dip the strip in the solution for one (1) second. 2) Remove the strip from the fluid and shake off excess dialysate. 3) Within 20 to 25 seconds, compare the color reaction on strip to the color chart on bottle to determine the closest match. 4) Match the strip as closely as possible to one of the color scales on the bottle and read the pH range listed above the matched color. 5) pH test results should be between 6.9 – 7.6. The Facility Administrator or designee will conduct observational audits of teammates performing testing for pH daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly x 3 months. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality	

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			Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
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. Based on observation, record review, and interview, the facility failed to provide adequate lighting to maintain a safe treatment environment for 2 of 3 observation days. Findings include: 1. A policy titled "Physical Environment" was provided by the Manager of Clinical Services (MCS) on 04/23/2024. The policy indicated the facility would provide a safe and comfortable environment. 2. The treatment floor observations during the survey evidenced the following:	V 0401	V401 The Facility Administrator will in-service all clinical teammates on Policy 8-04-01 “Physical Environment”. Verification of attendance will be evidenced by an in-service signature sheet. Teammates will be educated using surveyor observations as examples, with emphasis on, but not limited to the following 1) The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable	05/24/2024

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	During a treatment floor observation on 04/22/2024 between 10:10 AM and 4:00 PM, dim lighting was present while patients were dialyzed and during medication preparation. During an observation on 04/22/2024 at 10:30 AM, Patient #5 was receiving dialysis treatment in the isolation room with the lights off. During a treatment floor observation on 04/23/2024 at 8:10 AM, evidence showed that the lights were turned off above stations 1 through 4. The lights were dimmed throughout the rest of the treatment floor area while patients were dialyzed. During an observation on 04/23/2024 at 8:30 AM, Patient #20 was receiving dialysis treatment in the isolation room with the lights off. During an observation on 04/24/2024 at 9:30 AM, Patient #5 was receiving dialysis treatment in the isolation room with the lights off. During a medication preparation and administration observation on 04/24/2024 at 10:20 AM, Registered Nurse (RN) 1 withdrew medication from a vial to a syringe and administered medication without adjusting overhead lights. RN 1 failed to prepare medicines in a well-lit area. 3. During an interview on 04/22/2024 at 10:15 AM, Registered Nurse (RN) 1 was asked why the overhead lights were dimmed. RN 1 stated that the patients liked it that way. RN 1 did not indicate that she turned up the lighting during medication preparation or at shift changes. 4. During an interview on 04/22/2024 at 4:40 PM, the Manager of Clinical Services (MCS) was		treatment environment. 2) Teammates will be able to visualize patients at all times during hemodialysis treatments for patient safety. The Facility Administrator submitted a work order for inspection of the lighting system and modification to prevent dimming of lighting in the treatment area. The Facility Administrator instructed teammates that dimming of lights in the treatment area is prohibited. The Facility Administrator of designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with	

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	informed the facility was cited for dimmed lighting in the treatment area on their last survey and was asked why the facility continues to have low lighting in the treatment area. The MCS stated she was aware of the past citation and was aware staff continued to turn the lights down despite facility audits. The MCS states the expectation was for staff to turn up the lights when drawing up medications and at shift change. 5. During an interview on 04/23/2024 at 4:30 PM, the MCS and Facility Administrator (FA) were made aware that staff continued to dialyze a patient In the isolation room with the lights off and continued to dim the lights on the treatment floor area while patients were receiving dialysis and during medication preparation. The MCS stated that staff were educated earlier in the day about the lighting in the treatment area and were still determining why staff continued to dim the lights. 6. During an interview on 04/24/2024 at 1:40 PM, MCS and the FA were made aware that the overhead lighting remained dim the entire day, and a patient was dialyzed in the isolation room with the lights off. The MCS stated staff were educated on 04/22/2024 and 04/23/2024. The FA stated that the staff continued to dim the lights and would have one-to-one education with RN 1 and the other staff. The FA said the lights should not be turned off in the isolation room while a patient receives dialysis. 7. During an interview on 04/25/2024 at 9:00 AM, the Medical Director (MD) stated that after the last survey, we had the windows tinted due to the sun. The MD stated that they are promoting a calm environment by having the lights dimmed. He then stated that the FA reached out to him,		this plan of correction.	

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	and they were coming up with some ideas.			
V 0542 Bldg. 00	494.90(a) POC-IDT DEVELOPS PLAN OF CARE The interdisciplinary team must develop a plan of care for each patient. Based on record review and interview, the facility failed to ensure the plan of care (POC) was complete, accurate, and dated for 5 of 5 record reviews. (Patients #1, #2, #3, #4, #5) Findings include: 1. A policy titled "Medical Records Documentation Guidance" was provided by the Manager of Clinical Services (MCS) on 04/23/2024. The policy indicated that all entries must be accurate and complete. 2. A policy titled "Interdisciplinary Team (IDT) Patient Assessment and Plan of Care" was provided by the Facility Administrator (FA) on 04/24/2024. The policy indicated the IDT will be responsible for creating and executing a plan of care (POC) for each patient. The initial plan of care must be completed within 30 days, and the subsequent plan of care following a reassessment must be completed within 15 days of completing the reassessment. 3. A review of Patient #1's plan of care dated 07/17/2023, failed to ensure a date behind each team member's name that indicated the date it was reviewed. 4. A review of Patient #2's record failed to evidence a start date for the POC. The POC did not include dates indicating when each team member reviewed and approved it.	V 0542	The Facility Administrator will in-service Interdisciplinary Team (IDT) members on Policy 3-02-02 “Medical Records Documentation Guidance” and Policy 1-14-01 “Interdisciplinary Team (IDT) Patient Assessment And Plan of Care” beginning 4/24/24. Verification of attendance will be evidenced by an in-service signature sheet. IDT members will be educated using surveyor observations as examples, with emphasis on, but not limited to the following: 1) All entries must be accurate. 2) Document accurately and concisely but completely. 3) The facility’s interdisciplinary team will develop and implement a written, individualized comprehensive plan of care that specifies the services necessary to address the patient’s needs, as identified by the comprehensive assessment and changes in the patient’s condition, and will include measurable and expected outcomes and estimated timetables to achieve these outcomes. 4) An initial Plan of Care, based on the findings from the comprehensive assessment, will be completed on all patients	05/24/2024

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	5. A review on 04/24/2024, of Patient 3's plan of care dated 04/14/2024, failed to ensure a date behind each team member's name that indicated the date it was reviewed and approved and failed to include the dietician and provider's signature. 6. A review on 04/24/2024, of Patient 4's plan of care dated 04/10/2024, failed to ensure a date behind each team member's name that indicated the date it was reviewed and approved and failed to include the provider's signature. 7. A review of Patient #5's record failed to evidence a date the plan of care (POC) started. The POC failed to ensure a date behind each team member's name that indicates the date it was reviewed and approved. 8. During an interview on 04/23/2024 at 11:00 AM, the Registered Dietician (RD) 2 stated that the Interdisciplinary Team (IDT) members are responsible for reviewing and approving the POC. Once the POC is approved, each IDT member must sign and date it. RD 2 also mentioned that it is the responsibility of Registered Nurse (RN) 1 to date the POC when it starts and to update the end date when each IDT member reviews and approves it. 9. During an interview on 04/23/2024 at 4:40 PM, the MCS stated the dietician was responsible for ensuring the POC was dated. At the same time, the FA stated it was RD 2's responsibility to ensure the POC was dated. 10. During an interview on 04/24/2024, at 2:00 PM, the Facility Administrator indicated plan of care should have been signed and dated by the clinicians and indicated the nurse practitioner could have signed the plan of care and was at the		new to dialysis within 30 calendar days (or 13 outpatient dialysis sessions for hemodialysis) beginning with the first outpatient dialysis treatment or per state guidelines. 5) The Plan of Care following re-assessments must be completed within 15 days of completing the re-assessment. 6) The patient's plan of care will be completed by facility's interdisciplinary team, including patient or personal representative and be signed by team members including the patient or the patient's personal representative. The Facility Administrator or designee will audit one hundred percent (100%) of plans of care monthly x 3 months to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of plans of care monthly x 3 months during the internal medical record audit. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans	

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	facility every week.		developed when needed until sustained compliance is achieved. Supporting documentation will be 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 dialysis facility failed to ensure patient dialysis prescription orders were adhered to in order to achieve and sustain the prescribed dose of dialysis to meet the adequacy of dialysis in 1 of 5 treatment records reviewed (Patient #3). Findings include: A policy revised 04/2024, titled, "Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment," indicated intradialytic treatment monitoring and data collection would be completed every 30 minutes and include but not limited to obtaining blood a dialysate flows, and if the dialysis prescription was not being met (including dialysis flow rate or change to blood flow rate) the reason would be documented, and the licensed nurse informed. A clinical record review for Patient 3's dialysis treatment sheets from 04/01/2024-04/22/2024 evidenced the following:	V 0544	The Facility Administrator in-serviced all clinical teammates on Policy 1-03-08 “Pre-Intra-Post Treatment Data Collection, Monitoring, And Nursing Assessment” beginning 4/24/24. Verification of attendance will be evidenced by an inservice signature sheet. Teammates will be educated using surveyor observations as examples, with emphasis on, but not limited to the following: 1) Vital signs and treatment monitoring: Nonnocturnal treatments are completed at least every thirty (30) minutes. 2) At a minimum, obtain and document the following: … Blood and dialysate flows…3) 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	05/24/2024

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	The flowsheet dated 04/01/2024 documented Patient 3's prescribed BFR (blood flow rate) was to be 400 ml/min (milliliters/minute). During treatment that began at 5:28 AM the BFR was lowered from 400ml/min to 350 ml/min at 6:04 AM and remained at 350 ml/min until 8:50 AM. The review failed to evidence why the patient did not receive the prescribed BFR. The flowsheet dated 04/03/2024 documented Patient 3's prescribed BFR was to be 400 ml/min. During treatment that began at 5:28 AM the BFR was lowered from 400ml/min to 350 ml/min at 8:01 AM and remained at 350 ml/min until 8:41 AM. The review failed to evidence why the patient did not receive the prescribed BFR. The flowsheet dated 04/15/2024 documented Patient 3's prescribed BFR was to be at 400 ml/min. During treatment that began at 5:29 AM the BFR was lowered from 400ml/min to 350 ml/min at 6:01 AM and remained at 350 ml/min until 10:00 AM. The review failed to evidence why the patient did not receive the prescribed BFR. During an interview on 04/23/2024, at 1:12 PM, the Manager of Clinical Services indicated the BFR was not the prescribed BFR and the PCT (Patient Care Technician) should have documented the reason to lower the BFR and the PCT did not document why the BFR was not as prescribed. During an interview on 04/25/2024, beginning at 9:00 AM, the Medical Director indicated he would want to be notified if the patient's BFR was being lowered at an ongoing basis due to concerns over the patient's access and would expect to see documentation of the reason the BFR was being lowered during the patient's treatment.		and the licensed nurse informed. The Facility Administrator or designee will audit twentyfive percent (25%) of treatment detail reports daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports audited monthly x 3 months. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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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 Medical Director failed to ensure the facility staff upheld the safety measures regarding securing medications in a locked cabinet on 2 of 3 treatment area observation days; failed to ensure the facility staff used unexpired pH strips for dialysis solution testing with the potential to affect the safety of all patients receiving dialysis; and failed to ensure the patients received the prescribed medication at the correct time affecting 5 of 5 patients receiving in-center medication to take at home. (Patient #7, #8, #12, #15, #21) Findings include: 1. A 10/2023 revised policy, titled "Medication Policy," indicates medications are to be stored in a cabinet and locked when not under the supervision of a licensed team member. 2. A revised article dated 09/04/2023, titled "Nursing Rights of Medication Administration," indicates that the medication should be administered to the correct patient and given at the time indicated by the prescriber. 3. During a flash tour of the water room on 04/22/2024 at 10:10 AM, pH test strips had an expiration date of 11/30/2023.	V 0715	Governing Body meeting will be conducted with the Medical Director for review of the results of the survey conducted on 4/25/24. The Governing Body will review Policy COMP-DD-017 “Medical Director Qualifications and Responsibilities” with the Medical Director to include: 1) : 1) Medical Director responsibilities include, but are not limited to, the following…: Oversight of 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….Verification of the Medical Director’s attendance and understanding is evidence by his/her signature on the policy. The Facility Administrator will in-service all clinical teammates on Policy 1-06-01 “Medication Policy” and Policy 1-21-09 “Testing pH of Citric Acid Base Dialysate Using RPC E-Z CHEK K100-0117CT 6.8-8.5 Test Strips” beginning 4/24/24. Teammates will be educated using surveyor	05/31/2024

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	A document titled "E-Z Check 6.8 - 8.5 pH Test Strip Instructions for Use" indicated test strips should not be used after the expiration date printed on the bottle label. During an interview on 04/22/2024 at 10:15 AM, RN 1 confirmed that the test strips were expired and then returned the test strip container to the original location where the test strips were found. 4. During observation of medication preparation and administration on 04/22/2024, at 12:50 PM, RN 1 was observed entering an unlocked medication box to retrieve medication for Patient #1, then leaving the medication prep area with the medication box left unlocked and unattended by a team member. During treatment area observation on 04/23/2024 at 9:20 AM and 9:30 AM, the medication box at the medication prep area was found to be unattended and unlocked, with medication located inside. The facility staff failed to follow safety measures to secure unattended medication. During an interview on 04/23/2024 at 9:30 AM, RN 1 indicated medication box can be locked by turning knob. This action latches the box lid but does not secure the medication box with a lock to prevent unauthorized individuals from getting into the medication box. During treatment area observation on 04/23/2024 at 9:35 AM, a caregiver and patient walked behind the medication prep area where an unlocked medication box containing medication was located. The facility staff failed to follow safety measures to secure unattended medication and keep patients safe while in facility care.		observations as examples, with emphasis on, but not limited to the following: 1) 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) Medications are administered as prescribed and then documented in the patient's medical record. 3) No medications are given without an order from the physician or non-physician practitioner (NPP). 4) Do not use test strips from an opened or unopened bottle after expiration date printed on the bottle label. The Facility Administrator discarded the expired pH test strips on 4/22/24 and replaced them with new test strips with a current date. The Facility Administrator or designee will conduct observational audits daily x 2 weeks, then weekly x 2 weeks to verify compliance with facility policy for secured medication storage. Ongoing compliance will be verified monthly during the internal medication audit. The Facility Administrator or designee will audit one hundred percent of medical records for patients receiving oral medications during treatment to verify compliance with facility policy for documentation of a physician order for administration of medication during treatment. The Facility	

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	During an interview on 04/23/2024 at 10:30 AM, the Facility Administrator indicated that the medication box in the medication prep area should be locked and a code used to enter. 5. During discontinuation of dialysis observation on 04/22/2024 at 1:00 PM, a medication cup with medication was observed sitting on Patient #7's chair side table as PCT 3 prepared the patient to leave the facility. A clinical record for Patient #7 included a Treatment Details Report dated 04/22/2024, which indicated that the patient received two oral medications at 10:21 AM. The facility staff failed to administer medication at the time indicated on the Treatment Detailed Report. During an interview on 04/22/2024 at 1:00 PM, PCT 3 indicated Patient #7's medication on the chair side would be going home with the patient and that medications are left on a chair side table for patients to take during treatment; patients can opt to take medication home, that upset their stomach. 6. During treatment area observation on 04/23/2024 at 8:20 AM, 9:15 AM, and 10:08 AM, a medication cup with two pills was observed sitting on a chair side table while Patient # 12 slept. The clinical record for Patient #12 included a Treatment Details Report dated 04/23/2024, which indicated that the patient had received oral medication at 07:49 AM. The facility staff failed to administer medication at the time prescribed. During an interview on 04/23/2024 at 10:20 AM,		Administrator or designee will audit one hundred percent of treatment detail reports for patients with physician orders for administration of medication during treatment daily x 1 week, then weekly x 2 weeks to verify compliance with facility policy. Ongoing compliance will be verified with ten percent (10%) of treatment detail reports for patients with physician orders for administration of medication during treatment monthly x 3 months during the internal medical record report. Instances of non-compliance will be addressed. The Facility Administrator will review audit results with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings. The Facility Administrator will report progress, as well as any barriers to maintaining compliance. Action plans will be evaluated for effectiveness and new plans developed when needed until sustained compliance is achieved. Supporting documentation will be included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction	

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	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Patient #17 indicated that PO (by mouth) medications are brought to the chair side after being started on the dialysis machine and left in a cup on the chair side table. The patient indicated that medication is taken home and not taken until the afternoon because it irritates their stomach. The patient was unable to identify the medication in the cup on the chair side table. 7. During a medication preparation and administration observation on 04/24/2024 at 10:15, RN 1 removed Patient #7's medication from the medication box. Two pills had been placed between two medication cups, and they were taped across the top to hold the cups in place and to hold medication between cups so that the patient could take medication home at the end of treatment. 8. During an interview on 04/24/2024 at 10:15 AM, RN 1 indicated she takes two medication cups and places PO (by mouth) medication between the two cups, then tapes the two cups together for patients to take medications home and take later in the day. She indicated four patients at the facility she sends medication home with: Patient #7, Patient #8, Patient #12, and Patient #15. She indicated it was best practice for nurses to watch patients taking in-center medications, and she was not aware of the facility policy on sending medication home with patients. 9. During an interview on 04/24/2024 at 1:35 PM, the Facility Administrator indicated she was only aware of Patient # 21 taking in-center medication at home after treatment. She indicated medication should not be sent home with the patient without getting approval from a physician; she concluded there are no orders for Patients #7, #8, #12, #15, or #21 to take in-center medication home.			

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	10. During an interview on 04/24/2024 at 1:35 PM, the Manager of Clinical Services indicated no in-center medication should be sent home with the patient; the medication is in-center medication, not home medication. She indicated before in-center medication would be allowed to be sent home with the patient, the facility would need an order from the physician, approval from the governing body, and approval through risk assessment. None of these have been completed for Patients #7, #8, #12, #15, or #21. She indicated no policy addresses patients taking in-center medication at home. 11. During an interview on 04/25/2024 at 10:00 AM, the Medical Director indicated that staff could not chart medications administered if a patient took medications home. Medications given at the facility should not be sent home with the patient; they should be taken during dialysis treatment.			