STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152671	A. BUILDING 00 B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMMOND DIALYSIS CENTER	7 SIBLEY STREET HAMMOND, IN 46320

(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, for an ESRD supplier. Survey Dates: 07-12, 07-13, and 07-14-2022 Census: 64 At this Emergency Preparedness survey, Hammond Dialysis Center, was found not to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers at 42 CFR 494.62. QR by Area 3 on 7-19-2022	E 0000	The governing body and management staff of this facility takes this deficiency statement very seriously and will ensure that these citations are corrected and that they remain in compliance. The governing body met on 8/16/2022 to review and approve the plan of correction and the tools that will keep approved plan in compliance. The in-services and tools are attached and available for review in the facility. POC accepted on 8-29-2022 Deborah Franco, RN	
E 0018 Bldg. 00	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] 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			

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

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in			

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	the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure a process was in place to track patients and staff in the event of an emergency as observed in 3 of 3 survey days. Findings Include: 1. On 07-14-22 at 12:15 PM, a revised date of 05-29-09 policy titled, "Disaster Preparedness" was provided by the designated Administrator #4. The policy indicated but was not limited to, "	E 0018	An in-service was initiated to all nursing staff and on 8/16/2022 by the Clinic Manager (CM) on the importance of maintaining updated patient records located in the emergency evacuation box (**See attached in-service record).** Per the newly adopted emergency evacuation box policy it states "*4. Each emergency evacuation box shall have: A copy of the patient rounding*	08/26/2022

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	...Patients' records will be copied ..." 2. On 07-12-2022 at 11:30 AM, during the Flash Tour, the Emergency Preparedness Book was reviewed. The Emergency Preparedness Book contained the patient's demographics and treatment orders which were last updated on 06-02-2022, and failed to include all the current patients. 3. On 07-12-2022 at 3:30 PM, the Interim Administrator/Clinical Manager, indicated the current patient list should be in the communication book. The Administrator/Clinical Manager stated, "The patient list is not here as it should be. If it is not here it is not done."		*report. A copy of the center disaster plan. A copy of the chemical inventory and location form, and A roster of all center associates' home or mobile phone numbers."* During the in-service the policy was reviewed with staff and it was stressed that the emergency box must include a current list of all patient rounding report, which includes, patients' names and physician orders. This report must be updated on a monthly basis, when completing the monthly emergency box checks, to ensure it is current and contains all patient's currently dialyzing in the facility. The facility updated the rounding report to ensure all current patients are listed on the report. The emergency box is to be checked on a monthly basis. In addition to the monthly emergency box checks, the Charge Nurse (CN), at the end of each treatment day, will update the patient rounding report with any new admissions or discharges, to ensure the new patient information, along with physician orders, are added to the emergency box and discharged patient information is removed. The clinic manager will review the emergency box weekly for 8 weeks, to ensure the patient rounding report is up to date with all active patients **(See attached CM monitoring tool)**. The clinic manager will ensure compliance	

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			through direct observation and the use of the CM monitoring tool. The CM monitoring tool will be brought to the monthly Total Quality Management (TQM) meeting, where all findings will be reviewed and further action will be taken as deemed appropriate by the committee such as continuing the weekly monitoring or if trends are identified disciplinary action.	
V 0000 Bldg. 00		V 0000	The governing body and management staff of this facility takes this deficiency statement very seriously and will ensure that these citations are corrected and that they remain in compliance. The governing body met on 8/16/2022 to review and approve the plan of correction and the tools that will keep approved plan in compliance. The in-services and tools are attached and available for review in the facility.	
	This visit was for a Federal Recertification Survey of an ESRD supplier. Survey Dates: 7-12, 7-13, and 7-14-22 ICHD: 58 PD: 6 Census: 64 Stations: 29 including the isolation room. QR by Area 3 on 7-19-2022			
V 0115 Bldg. 00	494.30(a)(1)(i) IC-GOWNS, SHIELDS/MASKS-NO STAFF EAT/DRINK Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur			

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	(e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. Based on record review, observation, and interview, the facility failed to ensure patients (Patients: #5 and 14) followed infection control practices to prevent the spread of COVID-19 infection and the facility failed to ensure staff members wore face shields while performing procedures when spattering of blood might occur (Employees: Interim Administrator/Clinical Manager and RN #1) observed over 2 of 3 survey days. Findings Include: 1. On 07-14-22 at 12:00 PM, a revised date of 07-12-22 policy titled "COVID-06 COVID-19 Screening Policy & Protocol," was provided by the designated Administrator #4. The policy indicated but was not limited to, " ... The patient must put on a surgical mask upon entry into the facility ..." 2. On 07-14-22 at 11:30 AM, a revised date of 09-03-15 policy titled "Infection Control/Bloodborne Pathogens Exposure Control Plan," was provided by the designated Administrator #4. The policy indicated but was not limited to, " ... Surgical masks in combination with eye protection devices, such as goggles, or chin-length face shields are required to be worn whenever splashes, spray, splatter, or droplets of blood or [other potentially infectious materials] OPIMs may be generated ... " 3. During an observation on 07-12-2022 at 2:30	V 0115	An in-service was initiated to all Direct Patient Care (DPC) staff, including Employee #2 and RN #1 on 8/17/2022 by the Clinic Manager (CM) on proper use of Personal Protective Equipment (PPE) including facemask and shields **(See attached in-service record)**. It was stressed during the in-service that patients and DPC staff must wear appropriate PPE, including a surgical mask, to prevent the spread of COVID, and staff must wear a mask and face shield or goggles, when there is a risk of exposure from blood and bodily fluids. The following was stressed during the in-service: · Per policy "The patient must put on a surgical mask upon entry into the facility." If the patient is wearing a cloth mask, staff must educate the patient that a surgical mask must be worn, while in the facility, to prevent the spread of COVID and provide the patient with a surgical mask, prior to entering the treatment floor. · All staff must wear appropriate mask and face shield or goggles when assisting patients at the dialysis station (i.e. adjusting a patient's central	08/26/2022

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	PM, Patient #5 was observed at station #15, wearing a purple cloth mask during their treatment. 4. During an observation on 07-13-2022 at 10:36 AM, Patient #14 was observed at station #5, wearing a pink and gray cloth mask during their treatment. 5. During an interview on 07-13-2022 at 4:25 PM, the Interim Administrator/Clinical Manager confirmed the staff were supposed to change the patient's masks to a surgical mask if the patient came in wearing a cloth mask into the facility. 6. During an observation on 7-13-22 at 11:35 AM, Employee #2, Interim Administrator, was observed not wearing a face shield while adjusting the central venous catheter of Patient #15. 7. During an observation on 7-13-22 at 11:40 AM, RN #1, was observed wearing a visor above the her face while adjusting the dialysis setting (in close proximity to the patient's access site and blood lines) at station #24 for Patient #26.		venous catheter). Additionally, the face shield must be worn properly, over the staff members face and not above the face. These items have been added to the monthly Infection Control (IC) Audit which will be done weekly for 8 weeks by an assigned Direct Patient Care (DPC) staff member **(See attached IC Audit).** All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will spot check the treatment floor, weekly for 8 weeks, to ensure staff and patients are wearing PPE appropriately at all times as listed above **(See attached CM monitoring tool).** The Clinic Manager will ensure compliance through direct observation and review of the Infection Control Audits at least monthly prior to the Total Quality Management (TQM) meeting. All findings will be addressed at the monthly TQM meeting, where additional action will be taken as deemed appropriate, such as additional training, continuing the weekly audits or if trends are identified, disciplinary action.	
V 0147 Bldg. 00	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children			

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	I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters. II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site. Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients. VI. Catheter and catheter-site care B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections]. Based on record review and observation, the agency failed to follow infection control practices for 2 of 2 central venous catheter (CVC) initiations (Patients 2 and 7) and 2 of 2 CVC's discontinuations (Patients 13 and 14.) 1. A policy titled "CVC: INITIATION & DISCONTINUATION OF TREATMENT PROCEDURE #IC05-A," received on 7-13-22 at 9:01 AM from the Designated Administrator indicates but is not limited to the following: " ...Disinfect according the manufacturer's	V 0147	An in-service was initiated to all DPC (Direct Patient Care) staff on 8/16 & 8/17 by the Clinic Manager (CM) regarding the procedure for initiation and termination of the dialysis treatment with a Central Venous Catheter (CVC) **(See attached in-service record).** It was stressed during the in-service that staff must follow all facility policies and manufacturer guidelines for initiating and discontinuing treatment of the	08/26/2022

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	instructions ... " 2. A policy titled "TREATMENT INITIATION-CATHETER" received on 7-14-22 at 11:25 AM from Employee #4, Designated Administrator, indicated but was not limited to the following: "Scrub connection between catheter end caps and catheter port with approved antiseptic and wrap in 4 X 4 dressing soaked with approved antiseptic for 5 minutes." 3. A review of the directions for use stated but was not limited to the following: Alcavis 50 solution... Procedure: "Carefully place the catheter venous port in an Alcavis 50 saturated 4 X 4 gauze pad and scrub the catheter end and port for 1 minute. Carefully place the catheter arterial port in an Alcavis 50 saturated 4 X 4 gauze pad and scrub the catheter end and port for 1 minute. Make sure to rub in an agitating motion when cleaning ports. Carefully wrap the arterial port in an Alcavis 50 saturated gauze pad. Carefully wrap the venous port in an Alcavis 50 saturated gauze pad. Leave each port wrapped for at least 2 minutes. Carefully unwrap the catheter ports for initiation of dialysis treatment as per clinic protocol. Repeat this process for the discontinuation of the dialysis treatment as per clinic protocol." 4. During an observation on 7-12-22 at 11:25 AM, Employee #1, Patient Care Technician (PCT), was observed initiating dialysis on Patient # 2. Employee #1 disinfected the open hub by wrapping a 4 X 4 gauze with Alcavis 50, (Antiseptic) for one (1) minute prior to initiating		patient with a CVC. This includes the proper manufacturer guidelines, for Alcavis, are followed ensuring the catheter end and port are scrubbed for 1 minute, and then soaked for 1 minute. It was stressed that the staff member must use the clocks to time the scrub and soak to ensure the proper amount of contact time is followed. All Direct Patient Care (DPC) staff will be observed, by the CM, performing the initiation and termination of dialysis with the CVC, to ensure the scrub and soak time are followed. Each staff member will have a certificate of competency signed by the Clinic Manager and the Medical Director in their personnel file by 8/26/2022 **(See attached Certificate)** demonstrating competency. These items have been added to the monthly Infection Control (IC) Audit which will be done weekly for 8 weeks by an assigned Direct Patient Care (DPC) staff member **(See attached IC Audit).** All breaks in Infection Control will be immediately addressed by the Clinic Manager. Additionally, The CM will spot check the treatment floor, weekly for 8 weeks, to ensure staff are following the manufacturer guidelines for the correct scrub and soak time **(See attached CM monitoring tool).** The Clinic Manager will ensure	

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	dialysis. Employee #1 confirmed the hub had been wrapped in Alcavis 50 for one (1) minute and explained that was the procedure they were taught. 5. During an observation on 7-13-22 at 10:39 AM, Employee #6, PCT, was observed initiating dialysis on Patient #7, employee #6 disinfected the open hub by wrapping a 4 X 4 gauze with Alcavis 50 for one (1) minute prior to initiating dialysis. 6. During an observation on 07-13-22 at 9:56 AM, RN #6 was observed scrubbing the hubs of the CVC for Patient #13 when discontinuing their treatment. RN #6 failed to disinfect the hub for 1-2 minutes. The RN scrubbed the hubs for 15 seconds. 7. During an observation on 07-13-22 at 10:25 AM, RN #6 was observed scrubbing the hubs of the CVC for Patient #14 when discontinuing their treatment. RN #6 failed to disinfect the hub for 1-2 minutes. The RN scrubbed one hub for 15 seconds and the other hub for 16 seconds. During an interview on 07-13-2022 at 4:25 PM, the Interim Administrator/Clinical Manager confirmed the CVC hubs were to be scrubbed for 1 minute. During an interview on 07-14-22 at 8:05 AM, the Home Dialysis Nurse, RN #3, indicated when using the [Alcavis] scrubbing of hubs is a 5-minute soak and 2-minute scrub.		compliance through direct observation and review of the Infection Control Audits at least monthly prior to the Total Quality Management (TQM) meeting. All findings will be addressed at the monthly TQM meeting, where additional action will be taken as deemed appropriate, such as additional training, continuing the weekly audits or if trends are identified, disciplinary action.	
V 0402 Bldg. 00	494.60(a) PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY The building in which dialysis services are			

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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 and interview, the facility failed to ensure the safety of patients and staff as observed over 3 of 3 survey days. Findings Include: 1. On 07-12-2022 at 11:20 AM, during a flash tour, observed were eight boxes containing bags of Peritoneal Dialysate found on the floor of the home dialysis supply closet. 2. On 07-12-2022 at 11:55 AM, during a flash tour, observed were broken down-boxes, a Styrofoam cooler on the floor by the back door, and a box labeled Christmas decorations by the back wall of the dialysis supply storage room. 3. On 07-13-2022 at 4:35 PM, observed in the supply room and kept the broken-down boxes were a Styrofoam cooler and a box of Christmas decorations on the supply room floor. 4. During an interview on 07-14-2022 at 9:01 AM, the designated Administrator #4, confirmed items are not to be stored on the floors. During an interview on 07-14-2022 at 12:30 PM, requested the agency policy for storage and building safety and the designated Administrator, employee #4, indicated "there is no policy on the safety of the building and storage."	V 0402	An in-service was initiated to all staff, including the Facility Technical Manager (FTM) on 8/16/2022 by the Clinic Manager (CM) regarding the importance of maintaining a clean, safe, and sanitary environment at all times, to reduce the risk of cross contamination and to provide a safe and comfortable environment for patients, visitors, and staff **(See attached In-service Record).** During the in-service it was stressed that a pristine environment must be maintained and that each staff member at this facility is responsible for maintaining a clean environment. If a staff member identifies any unsanitary condition it must be cleaned immediately or reported to the CM or FTM for repair. This includes ensuring that boxes are not stored directly on the floor, including the floor in the home dialysis supply closet or storage room. The bags of peritoneal dialysate were being used for training purposes and have been discarded. All broken down boxes were also discarded. The Styrofoam cooler and box of decorations were relocated to a shelving unit. The monthly facility inspection checklist is completed by the Facility Technical Manager (FTM) and includes ensuring the	08/26/2022

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			facility is maintained at all times to ensure the environment is clean, safe, and comfortable. This includes ensuring that there are no boxes or other items stored directly on the floor. The CM will spot check the facility one day a week, for a minimum of 8 weeks, to ensure items are not stored on the floor in the home dialysis supply closet or storage room **(See attached CM monitoring tool)**. The CM will ensure compliance through direct observation and by reviewing the monthly facility inspection checklist prior to each monthly Total Quality Management (TQM) meeting. The CM monitoring tool and monthly facility inspection checklist will be reviewed at the monthly TQM meeting. All findings will be addressed at this meeting and additional action will be taken as deemed appropriate by the committee, such as more education, continuing the weekly monitoring or if trends are identified, disciplinary action.	