

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  012505	<b>(X3) Date Survey Completed</b>  07/21/2022
<b>Name of Provider or Supplier</b>  Physicians Choice Dialysis-Montgomery	<b>Street Address, City, State</b>  1001 Forest Avenue, Montgomery, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>E0000</b>	A recertification survey was conducted on 7/19/22 to 7/21/22 at Physicians Choice Dialysis - Montgomery. Standard level deficiencies were cited for Emergency Preparedness.
<b>E0028</b>	<p>Dialysis Emergency Equipment</p> <p>494.62(b)(9) Condition for Coverage: [(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, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of the facility's emergency equipment checklist, the facility schedule of PD (peritoneal dialysis) patients to be seen at the facility during the survey, and staff interviews, it was determined the facility failed to ensure PD emergency supplies were maintained. This deficient practice, failure to ensure immediate availability of viable oxygen supplies had the potential to result in a delay of staff response during an emergency and had the potential to negatively affect all patients receiving treatment in this PD home dialysis program. Findings include: 1. During the home program tour on 7/19/22 at 8:50 AM, an observation of the PD home program emergency equipment revealed one of one portable oxygen canisters had no available oxygen. The oxygen canister registered in the red, in need of a refill. Review of the home program document titled, Emergency Equipment Checklist Weekly</p>

	<p>Checks, revealed on 7/18/22, "oxygen tank(s) filled-adequate" documented by Home Program Registered Nurse (RN), Employee Identifier (EI) # 4. In an interview with EI # 4 on 7/19/22 at 8:40 AM, he/she confirmed the home program oxygen for emergency use was not available for patient use on 7/19/21. EI # 4 reported "it (oxygen) must be leaking". Review of the facility home program schedule revealed two patients were to be seen by the PD RN on 7/19/22 and two physicians were scheduled to see twelve patients at the facility on 7/20/22. On 7/20/22 at 8:30 AM the surveyor re-visited the home program area. The home program portable oxygen canister was not available for use in the event of an emergency on 7/20/22 and the oxygen continued to be in need of a refill. In an interview on 7/21/22 at 3:00 PM, EI # 2, Regional Home Program Director confirmed the staff had failed to ensure all PD home program emergency equipment was functional and available for use in the event on an emergency.</p>
<p><b>V0000</b></p>	<p>[ESRD Core Survey]</p>
<p><b>V0110</b></p>	<p>CFC-INFECTION CONTROL CFR(s): 494.30</p> <p>This CONDITION is not met as evidenced by: Based on observations, facility policies and procedures, Centers for Disease Control Hand Hygiene in Healthcare Settings Guidance and interviews with staff, it was determined the facility failed to ensure the staff followed infection control requirements per regulations and facility policies and procedures. Refer to V113, V116, V120, V122, V130, V131, V143 and V147 for findings.</p>
<p><b>V0113</b></p>	<p>IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1)</p> <p>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 station.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of facility policy, CDC (Centers for Disease Control) Hand Hygiene in Healthcare Settings Guidance and interviews, it was determined the facility failed to ensure: 1. Staff followed the policy for gloving and hand hygiene. 2. Patients performed hand hygiene after removing gloves and prior to exiting the treatment area including a patient treating in the isolation station. This affected one of three observations conducted for central venous catheter (CVC) care/treatment initiation, one of two discontinuation of treatment with CVC, one of three observations AV (Atrioventricular) fistula (AVF) or graft treatment initiation, and one of three discontinuation of dialysis treatments. This did affect Patient Identifier (PI) # 18, PI # 21, PI # 20, PI # 19 and had the potential to negatively affect all patients dialyzing at this facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Date revised: October 2021 Purpose: To minimize the spread of infection or blood borne pathogens in the dialysis facility environment. Teammate Hygiene 1. Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves... after patient and dialysis delivery system contact, between patients even if the contact is casual, ...and</p>

on exiting the patient treatment area... Teammate/ Patient Safety 11. Teammates will wear disposable gloves when caring for the patient or 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. 13. Gloves should be changed when: When soiled with blood, dialysate, or other body fluids. When going from a "dirty" area or task to a "clean" area or task... 14. Gloves should be provided to patients... if these individuals assist with procedures such as self-cannulation or holding access sites. 15. All personnel protective equipment (PPE) is to be removed as soon as possible if... contaminated... CDC Hand Hygiene in Healthcare Settings ...Healthcare Providers Clean Hands Count for Healthcare Providers ...When using alcohol-based hand sanitizer: Put product on hands and rub hands together Cover all surfaces until hands feel dry This should take around 20 seconds... Last Updated 1/8/21 During observations of care conducted 7/19/22 to 7/21/22 the following breaches in infection control hand hygiene and glove use were observed: 1. On 7/20/22 at 9:00 AM at station 13, Employee Identifier (EI) # 5 CCHT was observed with PI # 18 initiating dialysis via an AVF. EI # 5 with ungloved hands, documented at the computer adjacent to the dialysis station, retrieved the thermometer, monitored PI #18's temperature, and replaced the thermometer to a drawer beneath the computer screen /keyboard. Without first performing hand hygiene, EI # 5 gloved and disinfected PI # 18's access site with alcohol and betadine. 2. On 7/20/22 at 9:01 AM, EI # 9, CCHT, was observed discontinuing dialysis and post dialysis access care for AV Fistula or Graft for PI # 21. After the needles were removed, PI # 21 held pressure on the access sites with a gloved hand. After hemostasis was achieved, PI # 21 removed the glove, transferred to a wheelchair, was weighed on the scales in the wheelchair, and was rolled off the treatment floor by EI # 9. EI # 9 failed to ensure PI # 21 performed hand hygiene after removing his/her glove, and prior to leaving the treatment floor. 30952 3. On 7/20/22 at 9:35 AM at the isolation station, the surveyor observed PI # 20, with a gloved hand, hold the access site and obtained homeostasis (clotting). EI # 6, RN (Registered Nurse) applied a bandage to the access site and exited the isolation station. At 9:56 AM, PI # 20 removed/discarded his/her right hand glove and exited the isolation station to the in-center scales. PI # 20 touched the in-center scales. PI # 20 held the access site and failed to perform hand hygiene after glove removal. EI # 6 failed to ensure PI # 20 performed hand hygiene before exiting the isolation station. In an interview on 7/20/22 at 10:00 AM following the observation, EI # 6 confirmed PI # 20 did not perform hand hygiene after holding the access site following glove removal and before exiting the isolation unit. 4. On 7/20/22 at 10:20 AM at station 3 during CVC site care for PI # 19, EI # 7, RN placed 2 heparin syringes and CVC supplies on top of the dialysis machine, exited station 3 to the aisle, retrieved a chair, returned to the station 3. EI # 7 then donned gloves without first performing hand hygiene. During CVC exit care, EI # 7 removed the old CVC caps and removed gloves, sanitized hands, and waved his/her hands in air to dry. EI # 7 then donned gloves, scrubbed the catheter hubs with alcohol, removed gloves, sanitized hands for 3 seconds and with hands glistening wet, donned new gloves. EI # 7 failed to perform hand hygiene before donning gloves, sanitize hands for approximately 20 seconds and allow hand sanitizer to dry before donning gloves. EI # 7 placed the hourly heparin syringe onto the dialysis machine, labeled the CVC dressing, and removed gloves but failed to perform hand hygiene immediately after glove removal. After checking PI # 19's temperature, EI # 7 exited the station, returned to the station, donned gloves without first performing hand hygiene, placed a blue barrier under the CVC and secured the dialysis lines. EI # 7 failed to perform hand hygiene before donning clean gloves and after glove removal. 5. On 7/20/22 at 2:35 PM, EI # 7, RN, was observed discontinuing dialysis with CVC on PI # 19. EI # 7 placed the supplies on top of the dialysis machine, performed hand hygiene and donned gloves. With gloved hands, EI

# 7 pulled a rolling chair up to the station. With the same gloves, EI # 7 retrieved saline flush syringes from the top of the machine, disconnected the blood lines, and attached syringes and flushed both lines. EI # 7 retrieved alcohol swabs and caps from the top of the machine and cleaned the hubs and placed the caps on the CVC lines. EI # 7 then retrieved the ziplock bag with the barrier still folded inside and placed in the garbage. EI # 7 failed to place supplies on a clean barrier and failed to change gloves and perform hand hygiene after contaminating the gloves. In interviews conducted on 7/21/22 from 12:10 PM to 1:05 PM, EI # 1, Facility Administrator, confirmed the staff failed to follow facility hand hygiene policy and procedure and ensure patients performed hand hygiene after glove removal and upon exiting the facility.

**V0116**

IC-IF TO STATION=DISP/DEDICATE OR DISINFECT  
CFR(s): 494.30(a)(1)(i)

Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.

This STANDARD is not met as evidenced by:  
Based on observations, review of facility policy and interview, it was determined the facility failed to ensure the staff cleaned and disinfected equipment before returning it to a common clean area or being used on another patient. This did affect one of three observations conducted for access of AV (arteriovenous fistula) or graft for initiation of dialysis including Patient Identifier (PI) # 18 and had the potential to negatively affect all patients served by the facility. Findings include: Facility Policy: Infection Control for Dialysis Facilities Policy Number: 1-05-01 Date Revised: October 2021 Purpose: To minimize the spread of infections or blood borne pathogens in the dialysis facility environment. ...Dialysis Station Management ...65. Items taken into the dialysis station will be... cleaned and disinfected before taken to a common clean area or used on another patient... 1. On 7/20/22 at 9:05 AM at station 13, during an observation of access of AV initiation for dialysis treatment for PI # 18, Employee Identifier (EI) # 5, CCHT (Certified Clinical Hemodialysis Technician) took PI # 18's temperature then placed the thermometer in the open drawer beneath the computer at station 13. EI # 5 did not clean/disinfect the thermometer after use and before storing the thermometer at the station. At 9:11 AM, EI # 9, CCHT entered station 13, retrieved the thermometer and exited station 13. EI # 9 then used the dirty thermometer on an unsampled patient at station 7. Staff failed to ensure all re-usable equipment was cleaned/disinfected between patients. An interview was conducted on 7/21/22 at 12:10 PM with EI # 1, Facility Administrator, who confirmed the staff failed to follow the policy, clean and disinfect the thermometer before use on another patient.

**V0120**

IC-TRANSDUCER PROTECTORS-NOT WETTED/CHANGED  
CFR(s): 494.30(a)(1)(i)

Use external venous and arterial pressure transducer filters/protectors for each patient treatment to prevent blood contamination of the dialysis machines' pressure monitors.

If the external transducer protector becomes wet, replace immediately and inspect the protector. If fluid is visible on the side of the transducer protector that faces the machine, have qualified personnel open the machine after the treatment is completed and check for contamination. This includes inspection for possible blood contamination of the internal pressure tubing set and pressure sensing port. If contamination has occurred, the machine must be taken out of service and disinfected using either 1:100 dilution of bleach (300-600 mg/L free chlorine) or a commercially available, EPA-registered tuberculocidal germicide before reuse. Change filters /protectors between each patient treatment, and do not reuse them. Internal transducer filters do not need to be changed routinely between patients.

This STANDARD is not met as evidenced by:  
Based on observations, review of facility policy, and interview, it was determined the facility failed to ensure staff followed the policy for wet transducers. This had the potential to affect all patients dialyzing at this facility. Findings include: Facility Policy: Changing the Transducer Protectors Policy number: 1-03-11 Revision date: April 2021 Purpose: To provide guidance for changing transducer protectors and preventing cross contamination. Policy: 1. This policy is intended for all dialysis systems that utilize blood tubing sets with external pressure transducer protectors in the arterial and venous pressure monitoring system. ...3. External transducer protectors will be inspected for presence of blood or saline every 30 minutes during patient treatment and included as part of the monitoring process. 4. The external transducer protector will be replaced: - Prior to each patient use. -Whenever blood or saline is observed in contact with the patient side of the transducer protector. 5. If the external transducer protector becomes contaminated with blood or saline, the teammate will replace the external transducer protector... 1. During observations of care on the treatment floor on 7/19/22 at 9:03 AM, the surveyor observed a transducer wet with blood at station 3. The surveyor confirmed the wet transducer with Employee Identifier (EI) # 8, CCHT (Certified Clinical Hemodialysis Technician). EI # 8 changed the transducer at 9:05 AM, and immediately, the transducer became wet with blood again. The surveyor observed the transducer wet until dialysis was completed at 10:35 AM. An interview was conducted on 7/21/22 at 1:05 PM with EI # 1, Facility Administrator, who confirmed staff failed to monitor and change the wet transducer, per policy.

**V0122**

**IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL**  
CFR(s): 494.30(a)(4)(ii)

[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.

This STANDARD is not met as evidenced by:  
Based on observations, facility policy and procedure, and interview, it was determined the facility failed to ensure staff cleaned and disinfected the dialysis station after patient treatments per policy, and maintained dialysis chairs in good repair to allow for thorough cleaning and disinfection between patients. This affected two of two observations of the cleaning and disinfection of the dialysis station, an observation of preparation of the hemodialysis machine/ extracorporeal circuit for an unsampled patient, and had the potential to affect all patients dialyzed by this facility. Findings

include: Facility Policy: Infection Control for Dialysis Facilities Policy number: 1-05-01 Revision date: October 2021 Purpose: To minimize the spread of infections or blood borne pathogens in the dialysis facility environment. Policy: The Centers for Disease Control Recommendations for Preventing Transmission of Infections among Chronic Hemodialysis Patients will be followed when caring for all patients. ... Facility Hygiene ...46. Equipment including the... dialysis chair... IV (Intravenous) poles... will be wiped clean with a bleach solution... after completion of procedures, before being used on another patient... and after each treatment. 1. On 7/19/22 at 10:15 AM, EI # 5, CCHT (Certified Clinical Hemodialysis Technician), was observed cleaning and disinfecting dialysis station 14. While disinfecting the dialysis machine, EI # 5 failed to clean the four prongs of the IV pole. 2. On 7/19/22 at 11:21 AM, EI # 8, CCHT, was observed cleaning and disinfecting dialysis station 3. While disinfecting the dialysis machine, EI # 8 failed to clean the four prongs of the IV pole. 3. During observations on the treatment floor on 7/19/22 at 3:17 PM, the following was observed: a). Treatment chair at station 12 with an approximate six inch split in the headrest. b). Treatment chair at station 7 with an approximate 10 inch split in seat, with multiple small splits on both sides of larger split. 4. On 7/20/22 at 8:23 AM, EI # 8 was observed connecting the dialyzer and tubing to the dialysis machine at station 2. Following completion of machine set up, EI # 8, using both hands, pressed the garbage down in the garbage can. With the same gloved hands, EI # 8 closed both arms of the clean dialysis chair, and returned the chair to the upright position. EI # 8 then removed gloves, performed hand hygiene, and left the station. EI # 8 returned to the station with an unsampled patient and sat the patient in the contaminated chair. An interview was on conducted on 7/21/22 at 1:05 PM with Employee Identifier (EI) # 1, Facility Administrator, who confirmed staff failed to clean the dialysis station, per policy, and failed to provide dialysis chairs which could be thoroughly cleaned and disinfected.

**V0130**

**IC-HBV-ISOLATION-MACHINES/EQUIP/SUPPLIES**  
CFR(s): 494.30(a)(1)(i)

Isolation of HBV+ Patients To isolate HBsAg positive patients, ... dedicate machines, equipment, instruments, supplies, and medications that will not be used by HBV susceptible patients.

This STANDARD is not met as evidenced by:

Based on observation, review of facility policy, and interviews, it was determined the facility failed to ensure all equipment used in the isolation room was designated and labeled for "isolation" only. This had the potential to affect all Hepatitis B susceptible patients and staff at the facility. Findings include: Facility Policy: Hepatitis B Surveillance, Vaccination, Infection Control Measures and Isolation Guidance Policy number: 1-05-02 Revision Date: October 2021 Purpose: To prevent the spread of Hepatitis B infections in the dialysis setting. Policy: ...Dialyzing Confirmed Positive or Suspected/ Unknown Status ...15. Confirmed positive patients are dialyzed in an isolation room... Infection Control Measures for Confirmed Positive or Suspected/ Unknown Status ...19. Equipment/ Supplies a. Dedicated ancillary supplies such as ... bleach buckets, sharps' container... centrifuge, and non-disposable items will be used. b. Such supplies will be labeled "isolation" and will remain in the isolation room/ area or station and be disinfected after every patient use... 1. On 7/19/22 from 3:45 PM to 4:15 PM observations were made with EI (Employee Identifier) # 1, Facility Administrator in the isolation room during inspection of the equipment/supplies housed in the isolation unit. There was no isolation label on the following equipment

/supplies: Patient treatment chair Centrifuge Scale Sharps container Plastic dialysis supply container IV (Intravenous) pole Three plastic bleach containers with lids Patient privacy screen Mop In an interview conducted on 7/19/22 at 4:10 PM during the inspection, EI # 1 confirmed all equipment and supplies in the isolation room were not labeled and designated for isolation only use.

**V0131**

**IC-HBV-ISOLATION-STAFFING**

CFR(s): 494.30(a)(1)(i)

Isolation of HBV+ Patients Staff members caring for HBsAg positive patients should not care for HBV susceptible patients at the same time, including during the period when dialysis is terminated on one patient and initiated on another.

This STANDARD is not met as evidenced by:

Based on observations, review of facility policy, the Vaccinations and Surveillance Report, medical records, and interviews, it was determined the facility failed to ensure a teammate caring for a confirmed Hepatitis B surface antigen positive (HBsAg) patient, did not care for a surface antibody negative (susceptible/ non-immune) patient simultaneously. This affected one of two Hepatitis B surface antibody negative (susceptible) patients, including Patient Identifier (PI) # 22, who dialyzed at the same time as a HBsAg positive patient, PI # 20. This had the potential to negatively affect all susceptible (non-immune) patients and staff at the facility. Findings include: Facility Policy: Hepatitis B Surveillance, Vaccination, Infection Control Measures and Isolation Guidance Policy number: 1-05-02 Revision date: October 2021 Purpose: To prevent the spread of hepatitis B infections in the dialysis setting. Policy: 1. HBV (Hepatitis B Virus) serological status... and Hepatitis B Surface Antibody... of all patients should be known before admission to the hemodialysis facility. ...4. All patients will be routinely tested... 5. Results will be reviewed promptly to verify patients are managed appropriately based on their testing results. 6. Documentation of the following will remain in the patient's current active medical record: a. HBV serology results... 20. Seating a. Hepatitis B surface antibody positive (immune as evidenced by HBsAb greater than or equal to ( > ) 10) or core positive patients are seated between the confirmed or suspect hepatitis B surface antigen (HBsAg) positive patient and the susceptible patient to serve as a geographic buffer. 21. Teammate Assignment a. Teammates caring for confirmed or suspect hepatitis B surface antigen positive (HBsAg) patients do not care for surface antibody negative (susceptible) patients simultaneously and will only be assigned to care for surface antibody positive (immune) patients. 1. PI # 22 was admitted to the facility on 6/11/19 with diagnoses including ESRD (End Stage Renal Disease). Review of the Vaccinations and Surveillance Report, printed on 7/19/22 at 10:30 AM revealed PI # 22's Hepatitis B surveillance status was "Immune." Further review of the report listed PI # 22's HBsAb results dated 3/23/22 as 6 (six), and 6/22/22 as 4 (four), which was less than 10, and therefore not immune. An interview was conducted on 7/19/22 at 3:00 PM with Employee Identifier (EI) # 10, Manager of Clinical Services, who reported the buffer zone stations were 1 (one), 2 (two), 3 (three), 11, 12, 13, and 14. Review of the facility seating chart dated 7/20/22 revealed PI # 22 was assigned to sit at station 14, and scheduled to dialyze from 4:45 AM to 8:00 AM. A hepatitis B positive patient was scheduled to dialyze in the isolation room from 4:45 AM to 8:15 AM. An observation of care on the treatment floor was conducted on 7/20/22 at 7:45 AM. PI # 22 was dialyzing at station 13, which was in the buffer zone. PI # 20, a Hepatitis B positive patient, was dialyzing in the isolation room. EI # 6, Registered Nurse, was observed in the isolation room wearing gown, face shield, and gloves. Review of PI #

22's Treatment Sheet dated 7/20/22 revealed EI # 6 administered Heparin infusion, start time 4:54 AM and ended at 7:39 AM, Epogen 800 units, intravenous push at 5:05 AM, and Calcitriol 0.25 micrograms, oral, at 5:11 AM. Review of PI # 20's Treatment Sheet dated 7/20/22 revealed EI # 6 provided all care for PI # 20 in the isolation room, including initiating dialysis, administering IV medications, collecting blood for lab tests, and monitoring during dialysis, which ended at 9:16 AM. EI # 6 provided care for a Hepatitis B positive patient, and a susceptible patient at the same time, thereby putting PI # 22 at an increased risk of Hepatitis B infection. An interview was conducted on 7/21/22 at 1:10 PM with EI # 1, Facility Administrator, who confirmed the buffer zone stations were 1 (one), 2 (two), 3 (three), 11, 12, 13, and 14. EI # 1 further confirmed EI # 6 simultaneously cared for PI # 20 and PI # 22, which was not per policy.

**V0143**

**IC-ASEPTIC TECHNIQUES FOR IV MEDS**

CFR(s): 494.30(b)(2)

[The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and

This STANDARD is not met as evidenced by:

Based on observations, review of the facility's procedure and interviews, it was determined the facility failed to ensure the staff followed the procedure for medication administration and storage during one of three in-center medication administration and preparation (prep) observations. This affected PI (Patient Identifier) # 19 had the potential to negatively affect all patients who dialyzed at this facility. Findings include: Facility Procedure: 1-0601A Title: Preparation and Administration of Parental Medications (Non-EPO, Non-parsabiv) With all Dialyzer Types Revision Date: October 2021 Procedure: 1. Perform hand hygiene... 2. Prior to each medication preparation, disinfect the medication preparation surface with 1:100 (1 bleach/100 parts water) solution and disposable wipes. Remove gloves...Perform hand hygiene. 4. Place required supplies in disinfected medication preparation area. 17. Distribute the medication to the patient station in an aseptic manner. For example, place patient's syringe(s) in a reclosable bag if medication is not administered immediately. Do not place medication(s) directly on top of patient machine... 1. Observations on the in-center treatment floor were conducted on 7/20/22 from 9:25 AM to 11:30 AM. At 9:29 AM, the surveyor observed one bag of IDPN (intradialytic parental nutrition) laying on a counter next to a printer, a thermometer, and a rusty hole punch. At 11:30 AM, the IDPN bag was still laying on the counter next to the printer and the rusty hole punch. Staff failed to store the IDPN in a disinfected medication preparation area. 2. On 7/20/22 at 10:20 AM, EI # 7, RN entered station 3 with two IV (intravenous) heparin filled syringes, saline syringes, and central venous catheter (CVC) supplies (alcohol pads, catheter hubs) and placed the supplies on top of the dialysis machine. EI # 7 completed CVC exit care including saline flush and administered IV heparin to PI # 19 using the medication and supplies placed on top of the dialysis machine. An interview was conducted on 7/21/22 at 12:10 PM, EI # 1, Facility Administrator confirmed medications and supplies were to be stored in a designated clean area and not on top of the dialysis machine. 39098 3. On 7/20/22 at 2:35 PM, EI # 7, RN, was observed discontinuing dialysis with CVC on PI # 19. EI # 7 placed the supplies, including the saline flush syringes, on top of the dialysis machine. EI # 7 performed hand hygiene and donned gloves. With gloved hands, EI # 7 pulled a rolling chair up to the station. With the same gloves, EI # 7 retrieved saline flush

syringes from the top of the machine, disconnected the blood lines and attached syringes and flushed both lines. EI # 7 retrieved alcohol swabs and caps from the top of the machine and cleaned the hubs and placed the caps on the CVC lines. EI # 7 then retrieved the ziplock bag with the barrier still folded inside and placed in the garbage. EI # 7 failed to place the saline flush syringes and supplies on a clean barrier. An interview was conducted on 7/21/22 at 1:05 PM with EI # 1, who confirmed staff failed to maintain or store supplies and medications in an aseptic manner and not place supplies on top of the dialysis machine.

**V0147**

**IC-STAFF EDUCATION-CATHETERS/CATHETER CARE**  
CFR(s): 494.30(a)(2)

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].

This STANDARD is not met as evidenced by:

Based on review of medical records, facility policy and procedure, and interviews, it was determined the facility failed to ensure staff documented CVC (Central Venous Catheter) care per policy. This affected two of three records reviewed with CVC accesses, and did affect Patient Identifier (PI) # 5, and PI # 4, and had the potential to affect all patients dialyzing with CVC's. Findings include: Facility Policy: Central Venous Catheter Care Policy number: 1-04-02 Revision date: April 2022 Purpose: To reduce the risk of infection in the patient and to reduce trauma to the catheter and exit site while minimizing blood loss. Policy: ...2. Dressings are changed every dialysis treatment on: -Newly inserted cuffed catheters. -Cuffed catheter exit sites that are not well healed. -Exit sites with signs and symptoms of infection. -All CVCs not in use. ... 4. Cuffed catheters with well-healed exit sites... still require examination and cleaning of exit site each treatment. ...16. Document findings and interventions in patient's medical record. Facility Procedure: Central Venous Catheter with Clearguard HD (Hemodialysis) Antimicrobial End Caps Procedure Policy number: 1-04-02B Revision date: None listed (Origination Date April 2019) ...Notes: Use Dialysis Precautions and aseptic technique throughout procedure. ...DaVita's first choice for CVC care is 2% Chlorhexidine/ 70% Alcohol swab... Perform 15 second hub scrub every time a CVC is connected or disconnected from the blood lines... Procedure: 1. Perform hand hygiene per procedure. 2. ...Set up clean field with all appropriate supplies on a clean, moisture proof barrier. 3. Place patient in comfortable position... 4. Remove old dressing and discard. 5. Observe site for signs and symptoms of infection... 7. Remove gloves and discard. Perform hand hygiene per procedure and re-glove. 8. Holding catheter... clean exit site with 2% Chlorhexidine Gluconate/ 70% Isopropyl Alcohol swab for a minimum of 30 seconds... then wait 60 seconds for air dry time. 9. Clean each CVC limb/ cap... 10. Remove gloves and discard, perform hand hygiene... re-glove. ...12. Place sterile 2 (two) x (by) 2 (two) gauze over catheter

exit site... 14. Remove gloves and discard, perform hand hygiene... 1. PI # 5 was admitted to the facility on 7/12/22 with diagnoses including ESRD (End Stage Renal Disease). Review of two Treatment Detail Reports dated 7/12/22 and 7/14/22 revealed access type: CVC ...Dressing Change: Yes. There was no documentation of what CVC care was performed, per policy. An interview was conducted on 7/21/22 at 10:26 AM with Employee Identifier (EI) # 10, Manager, Clinical Services, who confirmed staff failed to document the CVC care performed. 2. PI # 4 was admitted to the facility on 5/16/22 with diagnoses including ESRD. Review of 5 Treatment Detail Reports dated 7/5/22, 7/7/22, 7/9/22, 7/12/22, and 7/14/22 revealed access type: AV (Atrioventricular) Graft, Additional Access Type: CVC ...Dressing Change: Yes. There was no documentation of what CVC care was performed on each of the treatment dates, per policy. An interview was conducted on 7/21/22 at 10:48 AM with EI # 1, Facility Administrator, who confirmed staff failed to document CVC care, per policy.

**V0543**

**POC-MANAGE VOLUME STATUS**  
CFR(s): 494.90(a)(1)

The plan of care must address, but not be limited to, the following: (1) Dose of dialysis. The interdisciplinary team must provide the necessary care and services to manage the patient's volume status;

This STANDARD is not met as evidenced by:  
Based on review of the medical records (MR), facility policy, and staff interviews, it was determined the facility staff failed to ensure changes in the patient condition which included BP (blood pressure) and heart rate (HR) were reported to the nurse. This affected three of five in-center records reviewed including PI (Patient Identifier) # 2, PI # 3, PI # 4, and had the potential to negatively affect all patients who dialyzed at the facility. Findings include: Facility Policy Title: CWOW (Clinic Without Walls)-Pre-Intra-Post Treatment Data Collection, Monitoring and Nursing Assessment Policy: 1-03-08 Revision Date: April 2021 ...Purpose: To obtain and document baseline and ongoing information about the patient before, during and after the dialysis treatment through data collection and nursing assessment... Policy: 1. Patient data will be obtained and documented by the PCT (Patient Care Technician) or a licensed nurse... Pre-Treatment Data Collection/ Assessment 4. Any abnormal findings or findings outside of any patient specific physician ordered parameters... will be documented and immediately reported to the licensed nurse... Intradialytic Data Collection/ Assessment ...9...may be performed by the PCT or licensed nurse and includes: ...b. At a minimum, obtain and document... i. blood pressure ii. Heart or pulse rate ...12. The licensed nurse notifies the physician... as needed of changes in patient status. 13. All findings, interventions and patient response will be documented... Abnormal Findings ...report ANY changes in patients conditions...immediately to the licensed nurse... Blood Pressure-Intradialytic: Difference of 20 mm/Hg (millimeters of mercury) increase or decrease from the patient's last intradialytic treatment BP reading... Heart or Pulse Pre/Intra/Post: Less than 60 beats per minute or greater than 100 beats per minute and/or irregular heartbeat... 1. PI # 2 was admitted to the facility on 5/24/19 with diagnoses including End Stage Renal Disease (ESRD). Review of the Treatment Details Report dated 7/12/22 revealed the PCT (Patient Care Technician) documented the following: At 10:57, treatment initiation, BP 136/60 treatment started without complications At 1:06 PM BP 145/63 At 1:30 PM BP 162/37, dia (diastolic) on bp low rechecked bp At 1:32 PM BP 143/32 dial low mask on; rechecked bp At 1:38 PM BP 146/32 rechecked bp pt (patient) alert no complaints, mask on There was

no documentation the PCT notified the RN (Registered Nurse) after the initial drop in diastolic BP of 26 mm/Hg which was sustained over the next 8 minutes. In an interview on 7/21/22 at 11:54 AM, EI (Employee Identifier) # 1, Facility Administrator confirmed staff failed to follow facility policy and notify the nurse with a change in the patients condition, a decrease in BP greater than 20 mm/Hg per policy. 2. PI # 3 was admitted to the facility on 3/19/21 with diagnoses including ESRD. Review of the Patient Summary Report printed 7/19/22 at 12:07 PM revealed medication orders dated 5/25/22 for Clonidine 0.1 mg (milligram) oral every 4 hours as needed. Review of the Treatment Details Report dated 7/5/22 revealed the PCT documented the following: At 7:02 AM BP 177/88 At 7:32 AM BP 97/52, (which was a difference of 80 mm/Hg systolic and 36 mm/Hg diastolic) Further review of the 7/5 /22 Treatment Details Report revealed at 8:02 AM (30 minutes later) the PCT rechecked the BP after the 80 and 36 mm/Hg decrease which was 153/77. Review of the Treatment Details Report dated 7/14/22 revealed the PCT documented the following: At 5:26 AM pretreatment standing BP 164/66, sitting 177/92 At 5:51 AM treatment initiation, BP sitting 186/86 At 6:00 AM BP 203/101 At 6:01 AM BP 188 /85 At 6:30 AM BP 171/83 At 6:59 AM BP 186/86 At 7:30 AM BP 186/91 At 7:35 AM BP 197/84 At 8:01 AM BP 185/75 At 8:30 AM BP 192/105, (a 30 mm/Hg diastolic increase) At 9:00 AM BP 183/92 At 9:30 AM BP 196/95 At 9:51 AM treatment terminated: BP 184/91 At 10:27 AM BP is elevated...no complications...RN notified Further review of the 7/14/22 Treatment Details Report revealed: At 10:28 AM Clonidine 0.1 mg oral was administered by the RN (the last BP 184/91) At 11:05 AM PCT documented, bp elevated (no BP was documented) At 11:17 AM RN documented, nephrologist rounding, administered additional Clonidine 0.1 mg for HTN (hypertension) At 12:05 PM, RN documented, standing BP 155/82, sitting BP 207/98, the patient was instructed by the nephrologist to take BP medication when he /she got home In an interview conducted on 7/21/22 at 12:04 PM, EI # 1 confirmed no Clonidine was administered during dialysis treatment as the PCT failed to notify the RN during treatment regarding PI # 3's elevated BP's. 39098 3. PI # 4 was admitted to the facility on 5/16/22 with diagnoses including ESRD. Review of the Treatment Details Report dated 7/16/22 revealed the Registered Nurse (RN) documented the following in the Treatment Nurse Assessment: Cardiovascular: Pre: Irregular Rhythm, Tachycardia Comment: Patient has elevated HR (Heart Rate) in 120's with fluttering. Dr. (Name) or on call doctor to be notified. Updated note to follow. Review of the intradialytic monitoring revealed the patient remained tachycardic from 5:14 AM to 8: 31 AM, with a range of 104 to 122 beats per minute. There was no documentation the RN notified the physician of the patient's heart rate of 120's with fluttering. An interview was conducted on 7/21/22 at 10:48 AM with EI # 1, who confirmed staff failed to notify the physician of the patient's tachycardia and irregular rhythm.

**V0550**

**POC-VASCULAR ACCESS-MONITOR/REFERRALS**  
CFR(s): 494.90(a)(5)

The interdisciplinary team must provide vascular access monitoring and appropriate, timely referrals to achieve and sustain vascular access. The hemodialysis patient must be evaluated for the appropriate vascular access type, taking into consideration co-morbid conditions, other risk factors, and whether the patient is a potential candidate for arteriovenous fistula placement.

This STANDARD is not met as evidenced by:  
Based on the review of the facility policy and procedure, medical records, and interviews, it was determined the staff failed to follow the policy and procedure for

AV (arteriovenous) fistula (AVF) access site cleaning/antiseptics and document the type of disinfectant used prior to access site cannulation. This affected three of three in-center records with AVF/Grafts which included PI (Patient Identifier) # 2, PI # 3, PI # 4 and had the potential to negatively affect all in-center patients who dialyze at the facility. Findings include: Facility Policy: 1-04-01 Title: AV (arteriovenous) Fistula and Arteriovenous Graft (AVG) Vascular Access Care Revision Date: April 2022 Policy: 4. Patients are encouraged to wash access extremity with soap and water upon arrival...If unable to wash access site, patient care teammate will clean access extremity with skin cleanings agent... 7. Acceptable skin antiseptics may include: Povidone iodine (PVP) ExSept Plus only for skin Isopropyl 70 % alcohol NOTE: Use Isopropyl 70 % alcohol as the single skin antiseptic ONLY when the patient has documented allergies to other skin antiseptics... Facility Procedure: 1-04-01E Title: AV (arteriovenous) Fistula (AVF) or Graft Cannulation with Nipro or Medisystems Safety Fistula Needles (SFN) and Administration of heparin Loading Dose Revision Date: April 2022 ...Materials required: Liquid soap or other skin cleanings agent 70% alcohol preps ...Skin antiseptic ... Notes: Check for patient sensitivity to preferred skin antiseptic/skin disinfectant listed in table below. Use Isopropyl as the single skin antiseptic ONLY when the patient has documented allergies to other skin antiseptics. Skin Antiseptic Povidone Iodine... Hypochlorite (ExSept Plus)... Isopropyl Alcohol 70 %... Procedure 1. Have patient wash access site with...antibacterial soap...If unable... teammate will clean with...skin cleansing agent... 10. While maintain aseptic technique, prep (prepare) each planned needle site by applying a 70 % alcohol prep pad to each site... 12. For patients who have...allergy to povidone iodine or ExSept Plus, necessitating alcohol alone, apply alcohol... 1. PI # 2 was admitted to the facility on 5/24/19 with diagnoses including End Stage Renal Disease (ESRD). Review of the Patient Summary Report revealed orders dated 6/8/22 for dialysis treatment three times a week via an AVF. Review of the Treatment Details Reports dated 7/5/22, 7/7/22, 7/9/22, 7/12/22, 7/14/22, 7/16/22 revealed no documentation of AVF cleaning and antiseptics with an acceptable antiseptic agent appropriate for the patient. In an interview on 7/21/22 at 11:54 AM, EI (Employee Identifier) # 1, Facility Administrator confirmed staff failed to document access antiseptics. 2. PI # 3 was admitted to the facility on 3/19/21 with diagnoses including ESRD. Review of the Patient Summary Report revealed orders dated 6/28/22 for dialysis treatment three times a week via an AVF. Review of the Treatment Details Report dated 7/5/22, 7/7/22, 7/9/22, 7/12/22, 7/14/22, 7/16/22 revealed no documentation of AVF cleaning and antiseptics with an acceptable antiseptic agent appropriate for the patient. In an interview was conducted on 7/21/22 at 12:04 PM, EI # 1 confirmed the staff failed to document AVF antiseptics. 39098 3. PI # 4 was admitted to the facility on 5/16/22 with diagnoses including ESRD. Review of the Patient Summary Report revealed orders dated 7/7/22 for dialysis treatments three times a week with access type: AV Graft. Review of 5 Treatment Details Reports dated 7/5/22, 7/9/22, 7/12/22, 7/14/22, and 7/16/22 revealed no documentation of AVG cleaning and antiseptics with an acceptable antiseptic agent appropriate for the patient. An interview was conducted on 7/21/22 at 10:48 AM with EI # 1, who confirmed staff failed to document access antiseptics.

**V0599**

**H-RECORDKEEPING SYSTEM**  
CFR(s): 494.100(c)(2)

(2) The dialysis facility must maintain a recordkeeping system that ensures continuity of care and patient privacy. This includes items and services furnished by durable medical equipment (DME) suppliers referred to in 414.330(a)(2) of this chapter.

This STANDARD is not met as evidenced by:

Based on review of facility policy, medical records, and interview, it was determined the facility failed to ensure the home treatment records were accurate and complete for:

1. Intraperitoneal (IP) antibiotic administration in one of one home peritoneal dialysis (PD) records reviewed with physician ordered IP antibiotics.
2. Dietician monthly progress notes in two of two home PD records. This affected Patient Identifier (PI) # 6 and PI # 7 and had the potential to negatively affect all patients who perform home PD with this facility.

Findings include: Facility Policy Title: CWOW (Clinic Without Walls)-Medical Record Quality Assurance Policy:3-02-07 Revision Date: April 2021 Purpose....medical records...provide continuity of care in a cohesive and linear manner... Policy: Documentation Requirements: Nurse: 14. As needed, provides documentation related to monitoring the patient condition, events, or occurrences before, during, or after treatments as well as general status review... Dietician: 19. Dieticians are required to record patient progress notes at least monthly for patients...All progress notes and plan of care follow-up notes are...dated...signed at the time they are written or entered electronically... 1. PI # 6 was admitted to the facility 2/2/18 with End Stage Renal Disease (ESRD) and PI # 6 performed home PD seven days a week. MR review revealed a PD Encounter Note dated 6/23/22 in which the physician documented, infection comments, "will continue vancomycin one (1) gm (gram) every 5 days times (x) 4 (four) doses, if worsens may need catheter removal." Further review of the 6/23/22 PD Encounter Note documentation revealed Nutrition Alb (Albumin) 3.3 low 060622 below. Review of the Patient Note documentation dated 6/23/22 at 2:24 PM completed by the PD Registered Nurse (RN) revealed the following: "...into the clinic see Dr. (doctor)...started Vancomycin 1 gm (gram) IP x (for) 4 (four) doses. Epo (epoetin) 38,000 units given at 1:00 PM... Tolerated well." Written questions provided to the facility on 7/21/22 at 7:55 AM requested documentation that PI # 6 received Vancomycin 1 gm at the clinic or home on 6/23/22, 6/28/22, 7/3/22 and 7/8/22 and for monthly dietician progress for past 60 days. In an interview conducted on 7/21/22 at 11:26 AM, EI (Employee Identifier) # 2, Regional Home Manager, provided documentation which confirmed PI # 6 started Vancomycin on 6/27/22, which was 4 days after the 6/23/22 PD encounter and received doses on 7/2/22, on 7/7/22 and on 7/12/22. EI # 6 reported PI # 6 left the clinic on 6/23/22 before starting the IP Vancomycin. EI # 2 confirmed the documentation did not reveal a delay in implementation of the 6/23/22 physician order for peritonitis treatment. In addition, EI # 2 confirmed no monthly dietician progress note was completed for June. 2. PI # 7 was admitted to the facility 3/31/2020 with ESRD and PI # 7 performed home PD seven days a week. Record review revealed a Plan Of Care Follow Up Note dated 4/1/22 completed by the dietician which revealed the following: low albumin 3.7- no change which was less than goal of greater than equal to four (4), ONS (oral nutritional supplement) initiate/continued-tolerating supplement. Further review of the MR revealed a physician PD Encounter Note dated 5/27/22 which revealed documentation, 5/5/22-albumin 3.3 low, below. There was no monthly dietician progress note documentation for May. Written questions were provided the facility on 7/20/22 at 3:55 PM requesting monthly dietician progress documentation. An interview was conducted on 7/21/22 at 11:10 AM with EI # 2 who confirmed there was no documentation the dietician completed a monthly progress note during May 2022 which addressed the albumin decrease.