Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	852554	07/26/2021
Name of Provider or Supplier	**Street Address, City, State**	
Panola Dialysis	5360 Snapfinger Woods Dr, Ste 102, Stonecrest, GA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
V0000	An onsite survey to investigate Complaint #GA00215364 and COVID-19 Focused Infection Control survey was conducted on July 26, 2021. The survey revealed that the facility was in substantial compliance with 42-CFR Part 494, Conditions for Coverage for End Stage Renal Disease Facilities. The allegation was substantiated. The following deficiency was cited:
V0554	POC-TRANSPLANT STATUS PLAN OR WHY NOT CFR(s): 494.90(a)(7)(ii) When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the- (A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with 494.80(a)(10). This STANDARD is not met as evidenced by: Based on a review of facility records, staff and patient interviews, and a review of policy and procedure, it was determined that the interdisciplinary team (IDT) failed to develop and implement plans of care for two of two Home Hemo Dialysis (HHD) patients (P#1 and P#4) sampled, who were on the active transplant list. Findings were: A review of the medical records revealed the following: - The care plans for P#1 and P#4 who were active on the transplant list from January 2021 - July 2021 lacked documentation regarding patient education on plans for transplantation and patient's understanding of their status as a transplant candidate. - There was a lack of documented follow through by the IDT and Social Worker (SW) to assist P#1 in pursuing transplantation. - There was no documented evidence that the SW responded to patient's needs related to transplantation including issues with insurance coverage

	that could negatively affect the patient's transplantation status. For example: During an interview with P#1 on 7/26/21 at 10:20 a.m., it was revealed that P#1 made several calls to the SW since May 2021 because of billing issues, but the SW was not responsive to her. P#1 stated that she was having benefit lapses since her Medicare claims were not submitted by the facility in a timely manner. P#1 stated that it was difficult to contact the SW since she was at a different facility when she called; messages were left, but that there was no call back. P#1 was concerned that her transplantation status would be negatively affected by this. A review of Policy 1-14-08 titled, "Transplant Referral and Tracking Process" revealed the following: The patient is included in the Plan of Care process. During Plan of Care meetings, the SW will discuss with the IDT the patient status, education to include patient's interest, referral and status as an active or inactive transplant candidate. Interviews with two of four HHD patients (P#2 and P#5 who were also on the active transplant list) on 7/26 /21 at 12:00 p.m. and 4:00 p.m. respectively, revealed that communications with the SW was poor, and that there were no timely reports/responses from her. The SW was slow to respond to them. Certain things were not followed through, and they had to remind her more than once about the same issues. P#5 stated that the SW was not informative enough about anything to help them financially, so that he won't be hit with crazy bills. He further stated "She does not return calls". A telephone interview with the SW on 7/26/21 at 2 :00 p.m. confirmed that she was at the facility once weekly, where the patients received dialysis services. She stated that she had a difficult time getting in touch with P#1, as she told her previously that she does not respond to numbers that she didn't know. Appointments were missed with the patient, therefore, emails and telephone calls were used to contact the patient. When there were no responses, the Home Dialysis Nurse was asked to relay messages from her. An interview with the the Home Dialysis Nurse on 7/26/21 at approximately 1:00 p. m. revealed that P#1 comes to the facility very depressed, and has not been dealing well with her dialysis diagnosis. The patient does not respond to calls at times, and that she, the Home Dialysis Nurse, had been the person relaying messages from the SW to the patient, and from the patient to the SW. During an interview with the Facility Administrator (FA) and Home Dialysis Coordinator on 7/26/21 at 2:00 p.m., the FA stated that the patients were educated, but was unable to provide the missing documentation.