

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  852586	<b>(X3) Date Survey Completed</b>  07/09/2025
<b>Name of Provider or Supplier</b>  Dialysis Care Center Gwinnett, Llc	<b>Street Address, City, State</b>  558 Old Norcross Road, Suite 104, Lawrenceville, GA	
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 at Dialysis Care Center Gwinnett, LLC from July 7, 2025 through July 9, 2025. The survey revealed that the facility was in compliance with 42 CFR Part 494.62, Conditions for Coverage for Emergency Preparedness Plan for End Stage Renal Disease facilities. No deficiencies were cited.
<b>V0000</b>	A Recertification survey was conducted at Dialysis Care Center Gwinnett, LLC from July 7, 2025 through July 9, 2025. The survey revealed that the facility was not in compliance with 42 CFR Part 494.40 - Water and Dialysate Quality and 42 CFR Part 494.180 - Governance, for End Stage Renal Disease Facilities. The following standard level deficiencies were also cited which resulted from the facility's noncompliance related to the survey:
<b>V0175</b>	<p>CFC-WATER &amp; DIALYSATE QUALITY CFR(s): 494.40</p> <p>This CONDITION is not met as evidenced by: Based on observation, staff interviews, a review of the manufacturer's Directions for Use (DFU) and a review of the facility's Policy and Procedures (P&amp;P), it was determined that the facility failed to ensure that there was a safe environment for all patients as evidenced by failure of two of three Patient Care Technicians (PCT AA and PCT BB) observed, to correctly verify the machine's final dialysate conductivity (ability of the dialysate to conduct electricity) and pH (acidity), according to the manufacturer's DFU and facility P&amp;P. This failure had the potential to negatively affect the health and safety of 11 of 11 patients who were receiving hemodialysis treatment at Station (S) 1, S2, S3, S4, S5, S6, S7, S8, S9, S11, and S12 at the time of this observation. Complications as minor as nausea and fatigue or as severe as metabolic acidosis (decrease in pH that could cause rapid breathing, confusion,</p>

dizziness, shortness of breath, chest pain) could result if dialysate composition is incorrect. And if the conductivity is out of the acceptable range, the effectiveness of the treatment is reduced and the patient's electrolyte balance could be altered. The facility census was 71. Findings include: Cross Reference: V 250 - Failure of the facility to ensure that two of three Patient Care Technicians (PCT AA and PCT BB) observed, correctly verified the machine's dialysate conductivity and pH, according to the manufacturer's DFU and facility P&P.

**V0250**

**DIALYS PROPORT-MONITOR PH/CONDUCTIVITY**  
CFR(s): 494.40(a)

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.

This STANDARD is not met as evidenced by:

Based on observation, staff interview, a review of the manufacturer's Directions for Use (DFU) and a review of facility Policy and Procedures (P & P), it was determined that the facility failed to ensure that there was a safe environment for all hemodialysis patients as evidenced by failure of two of three Patient Care Technicians (PCT AA and PCT BB) observed, to correctly verify the hemodialysis machine's final dialysate conductivity (ability of the dialysate to conduct electricity) and pH (acidity), according to the manufacturer's DFU and facility's P & P. This failure had the potential to negatively affect the health and safety of 11 of 11 patients who were receiving hemodialysis treatment at Station (S) 1, S2, S3, S4, S5, S6, S7, S8, S9, S11, and S12, at the time of observation. Complications as minor as nausea and fatigue or as severe as metabolic acidosis (decrease in pH that could cause rapid breathing, confusion, dizziness, shortness of breath, chest pain) could result if dialysate composition is incorrect. And if the conductivity is out of the acceptable range, the effectiveness of the treatment could be reduced and the patient's electrolyte balance could be altered. The facility census was 71. Findings include: During observation in the Patient Treatment Room on 7/7/25 between 10:15 a.m. and 11:51 a.m., the following was revealed: - PCT AA was observed at 10:47 a.m., verifying the machine's final dialysate conductivity and pH at S7, using the Myron L D-6-meter (a portable, multi-parameter water quality meter, used to measure conductivity, pH...). PCT AA obtained a dialysate sample from the machine and proceeded to fill the Myron L meter with two samples and then immediately read the results. During an interview on 7/7/25 at 10:50 a.m., PCT AA stated that he had already rinsed the Myron L meter cell once earlier, which was why he only used two additional samples to check the machine's pH and conductivity at S7. - PCT BB was observed at 10:52 a.m., verifying the machine's final dialysate conductivity and pH at S4. PCT BB obtained a dialysate sample from the machine and proceeded to fill the Myron L meter with one sample then immediately read the results. - PCT BB was observed at 11:36 a.m., verifying the machine's final dialysate conductivity and pH at S1, using the Myron L meter. PCT BB repeated the same incorrect procedure as mentioned above. During an interview on 7/7/25 at 11:48 a.m., PCT BB stated that she always collected a sample and filled the Myron L meter one time before reading the results. The Area Manager was notified of the above findings on 7/7/25 at 12:50 p.m. A review of the manufacturer's DFU on the "Digital Dialysate Meter", showed the following: Page 12-13 VII. SPECIFIC RECOMMENDED MEASURING PROCEDURES A. Measuring Conductivity & Total Dissolved Solids (TDS) Rinse

cell cup 3 times with sample to be measured. (This conditions the temperature compensation network and prepares the cell.) Refill cell cup with sample. Press COND or TDS. Take reading. C. Measuring pH (D-6) Remove protective cap by rotating while grasping and pulling up. Rinse pH/ORP sensor well and conductivity cell cup 3 times with sample to be measured. Shake out each sample to remove any residual liquid. Refill both sensor well and cell cup with sample. Press pH. Note value displayed A review of facility Policy: DCC-IC-DM-960-006 titled, "Myron L D-6 Measuring Procedures", with latest revision date of October 26, 2020, stated: Measuring dialysate conductivity and pH: 3. Rinse both the pH/ORP sensor well and conductivity cell three (3) times with the dialysate sample per dialysate meter IFU. Note: Because pH measurements require temperature compensation, ALWAYS fill both the pH sensor well and conductivity cell completely with the dialysate sample. 4. Refills the pH sensor well and conductivity cell completely with the dialysate sample. Note: Both the pH/ ORP sensor well and the conductivity cell MUST be rinsed and filled at least three (3) times with sample before each measurement is taken. 5. Press COND. Obtain reading. 6. Pushes the pH/ ORP parameter button to test the pH.

**V0556**

POC-COMPLETED/SIGNED BY IDT & PT  
CFR(s): 494.90(b)(1)

The patient's plan of care must- (i) Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.

This STANDARD is not met as evidenced by:  
Based on medical record review, staff interviews, and a review of facility Policy and Procedures (P&P), it was determined that the facility failed to ensure that five of seven sampled patients (P#1, P#3, P#4, P#6 and P#7), had a Patient Care Plan that reflected participation of all members of the Interdisciplinary Team (IDT), including the patient or patient representative. This lack of IDT collaboration and participation had the potential failure to identify new patients' concerns and outcomes that were not achieved. The facility census was 71. Findings include: During a review of patients' medical records, the following was revealed: - P#1 was admitted on 2/20/23. The Annual Care Plan was dated 6/11/25. - P#3 was admitted on 4/10/25. The 90-day Care Plan was dated 5/1/25. - P#4 was admitted on 5/20/25. The 90-day Care Plan was dated 6/16/25. - P#6 was admitted on 4/11/23. The Annual Care Plan was dated 8/13/24. - P#7 was admitted on 5/31/25. The 90-day Care Plan was dated 6/16/25. - There were no IDT signatures, nor any signatures from the patients or their representatives, as required per facility P&P in the development or discussion of the 90-Day and Annual Care Plans for P#1, P#3, P#4, P#6, and P#7. - A review of Policy DCC-IC-AD-100-007 titled, "Comprehensive Assessment & Plan of Care", with latest revision date of December 16, 2019, showed the following: II. Performed By: Interdisciplinary Team (Attending physician or physician extender [where permitted by State law], Registered Nurse [RN], Registered Dietician [RD], and Social Worker [SW], patient and/or care giver). Plan of Care Requirements The Plan of Care must be signed by the IDT members including the patient or designated care partner/caregiver. If the patient is unable or chooses not to sign the Plan of Care, this must be documented in the Plan of Care along with the reason the signature was not provided. During the exit interview on 7/9/25 at 12:30 p.m., the above findings were acknowledged by the Clinical Manager, and the Area Manager.

**V0750**

CFC-GOVERNANCE

CFR(s): 494.180

This CONDITION is not met as evidenced by:

Based on observations, staff interviews, a review of facility records, manufacturer's Directions for Use (DFU) and facility Policy and Procedures (P & P), it was determined that the Governing Body failed to demonstrate responsibility and accountability for the operations of the facility. This failure had the potential to negatively affect the health and safety of 71 patients who dialyzed at this facility. Findings include: Cross Reference: V 250 - Failure of the facility to ensure that two of three Patient Care Technicians (PCT AA and PCT BB) observed, correctly verified the machine's final dialysate conductivity (ability of the dialysate to conduct electricity) and pH (acidity), according to the manufacturer's DFU and facility P & P.