

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060

http://www.dail.vermont.gov

Survey and Certification Voice/TTY (802) 241-0480 Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

November 13, 2024

Mr. Jayesh Shukla, Director North Country Dialysis Unit 189 Prouty Drive Newport, VT 05855

Dear Mr. Shukla:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **October 23, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, BS Assistant Division Director State Survey Agency Director

Enclosure

PRINTED: 11/05/2024 FORM APPROVED QMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		473504	B. WING			10/23/2024	
NAME OF PROVIDER OR SUPPLIER NORTH COUNTRY DIALYSIS UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 189 PROUTY DRIVE NEWPORT, VT 05855				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
V 000	of North Country Dial Emergency Prepared result of the Emerger	site survey was conducted ysis re: requirements for ness on 10/23/24. As a cy Preparedness Survey, ory violations identified.	V	000			
	An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from 10/21/24 to 10/23/24 to determine compliance with 42 Code of Federal Regulations Part 405 Subpart U, Conditions for Coverage at 42 CFR 494.1-494.180: End Stage Renal Disease Services. The following regulatory violations were identified.				See plan of correction		12/15/24
V 113	CFR(s): 494.30(a)(1) Wear disposable glov patient or touching the dialysis station. Staff	es when caring for the patient's equipment at the must remove gloves and each patient or station.	V	113	Tag V 113 POC accepted on 11 by J. Kendall/P. Cota	/13/24	
	Based on observation failed to wear and chaperform hand hygiene patient care and care removes waste produthe blood when the ki functioning properly) a patients. (Patients #15	equipment for 2 applicable 2 & #13) Findings include:					
		10/21/24 at 11:30 AM, prior redure that involves inserting			TITLE		(Va) Patr

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

n

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 113	Patient #12's AV fistule between an artery and Technician (PCT) failed change gloves after or worn by touching the the top of their head a face in preparation for then inserted the first the safety glasses on to the top of their head hands and change glosecond line from their and took their safety ghead and placed then hand and proceeded then took the safety gmoved them up to the then secured the lines added information into computer, added a ganeedle insertion sites gloves. They then put hand sanitizing, re-adpressure cuff, took off sanitized. 2. Per observation on PCT removed their gloves on withou station #2 to assist other to accessing Patient # gloves are donned (puoff). They also confirm to accessing Patient # gloves are donned (puoff). They also confirm	r, into a vein or artery) of la (an abnormal connection d a vein), the Patient Care ed to cleanse hands and contaminating the gloves safety glasses wom upon and placing them upon their r initiation of dialysis. They needle and again touched their face and moved them d, again failing to cleanse oves. Then they took the machine with their right hand glasses from the top of their n on their face with their left to insert needle #2. They glasses from their face and et op of their head. They so the chair side stand up auze pad to the patient's and then removed their to on new gloves without glusted the patient's blood of their gloves and hand 10/21/24 at 12:05 PM the oves, exited station #5, put thand santizing and went to the r staff with patient #13. 6 PM, the PCT confirmed we been changed and hands and their safety glasses prior the patient safety glasses prior the first they should have a donning gloves when and conning gloves when a conning gloves when	V	1113	See plan of correction		12/15/24

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	care. They stated, "I a before putting on glov off." Per interview on 10/2 facility's medical direct sanitizing is required and after doffing glove. Per interview on 10/2 Manager RN RNS (Reconfirmed that it is a resolution sanitizing is done everor doffed gloves and subject of dean. They stated like touching hair, per glasses, any glasses, dirty and require glove sanitizing. IC-STAFF EDUCATION-CATHET CFR(s): 494.30(a)(2) Recommendations for Catheters in Adults are subject to the care worker of A. Educate health-care	#2 to assist with patient always try to hand sanitize res and after taking them 1/24 at 1:00 PM with the stor confirmed that hand when before donning gloves es. 1/24 at 1:15 with the enal Nurse Supervisor) requirement that hand ry time gloves are donned safety glasses are required at when there is any chance stated that gloves must be from clean to dirty and dirty that touching anything dirty sonal clothing, safety computer, are considered as changes and hand ERS/CATHETER CARE Placement of Intravascular and Children reducation and training re workers regarding the control measures to prevent related infections. of and adherence to refor all persons who	V 11	See plan of correction	3/24 by	12/15/24	

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V 147	Continued From page 3 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].		V	V 147 See plan of corre			12/15/24
	Based upon observat facility failed to ensure control measures were intravascular catheter y-shaped tube that is into a central vein in y-related infections for patients sampled. Findings include: Per observation on 10 Registered Nurse [RN dialysis initiation for Paccessing Pt.#4's Ceron the patient's left up	e appropriate infection re followed to prevent r (a flexible, long, plastic, threaded through your skin rour neck, chest or groin)* 1 patient [Pt.#4] of 3 0/21/24 at 12:45 PM, a staff t] was observed during rt.#4. While the RN was htral Venous Catheter [CVC] oper chest wall in s treatment, the patient was					

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V 147	Supervisor [RNS] on RNS confirmed that so dialysis patients with [CVCs] are wearing in de-accessing their CV intravascular catheter RNS confirmed that so on CVC accessing are expectation was the puring accessing and RNS confirmed the oraccordance with the forcedure. An interview was con Medical Director on 1 Medical Director state whether accessing a Catheter [CVC] during de-accessing the CVC the patient must be we control precautions, a done.	e facility's Renal Nurse 10/21/24 at 3:50 PM, the staff should ensure that Central Venous Catheters nasks during accessing and /C in order to prevent r-related infections. The staff are educated annually nd de-accessing, and the beatient is to be masked de-accessing the CVC. The bearvation was not in facility's CVC policy and ducted with the facility's 0/22/2024 at 1:00 PM. The ed that 'it doesn't matter' patient's Central Venous g initiation of dialysis or C after dialysis is completed, rearing a mask for infection and staff are to ensure this is	V	147	See plan of correction		12/15/24	

E 000 INITIAL COMMENTS

An unannounced on-site survey was conducted of North Country Dialysis re: requirements for Emergency Preparedness on 10/23/24. As a result of the Emergency Preparedness Survey, there were no regulatory violations identified

V 000 INITIAL COMMENTS:

An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from 10/21/24 to 10/23/24 to determine compliance with 42 Code of Federal Regulations Part 405 Subpart U, Conditions for Coverage at 42 CFR 494.1-494.180: End Stage Renal Disease Services. The following regulatory violations were identified.

V 113 IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1)

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.

This STANDARD is not met as evidenced by: Based on observation and staff interview, staff failed to wear and change disposable gloves and perform hand hygiene during the provision of patient care and care of dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly) equipment for 2 applicable patients. (Patients #12 & #13) Findings include:

- 1. Per observation on 10/21/24 at 11:30 AM, prior to cannulation (a procedure that involves inserting a cannula, or catheter, into a vein or artery) of Patient #12's AV fistula (an abnormal connection between an artery and a vein), the Patient Care Technician (PCT) failed to cleanse hands and change gloves after contaminating the gloves worn by touching the safety glasses worn upon the top of their head and placing them upon their face in preparation for initiation of dialysis. They then inserted the first needle and again touched the safety glasses on their face and moved them to the top of their head, again failing to cleanse hands and change gloves. Then they took the second line from the machine with their right hand and took their safety glasses from the top of their head and placed them on their face with their left hand and proceeded to insert needle #2. They then took the safety glasses from their face and moved them up to the top of their head. They then secured the lines to the patient with tape, added information into the chair side stand up computer, added a gauze pad to the patient's needle insertion sites and then removed their gloves. They then put on new gloves without hand sanitizing, re-adjusted the patient's blood pressure cuff, took off their gloves and hand sanitized.
- 2. Per observation on 10/21/24 at 12:05 PM the PCT removed their gloves, exited station #5, put new gloves on without hand sanitizing and went to station #2 to assist other staff with patient #13.

Per interview at 12:15 PM, the PCT confirmed that gloves should have been changed and hands cleansed after touching their safety glasses prior to accessing Patient #12's fistula and every time gloves are donned (putting on) or doffed (taking off). They also confirmed that they should have hand sanitized prior to donning gloves when proceeding to station #2 to assist with patient care. They stated, "I always try to hand sanitize before putting on gloves and after taking them off."

Per interview on 10/21/24 at 1:00 PM with the facility's medical director confirmed that hand sanitizing is required when before donning gloves and after doffing gloves.

Per interview on 10/21/24 at 1:15 with the Manager RN RNS (Renal Nurse Supervisor) confirmed that it is a requirement that hand sanitizing is done every time gloves are donned or doffed gloves and safety glasses are required "during site access and when there is any chance of blood spray." They stated that gloves must be changed when going from clean to dirty and dirty to clean. They stated that touching anything dirty like touching hair, personal clothing, safety glasses, any glasses, computer, are considered dirty and require gloves changes and hand sanitizing.

ACTION PLAN

- Under the direction of the Renal Nurse Supervisor all staff, applicable to their role received education on infection prevention
 practices specifically related to vascular access, performing hand hygiene and appropriate glove use as set forth by UVMMC
 policy RENL000047: Vascular Access: Needle Placement and Removal, including Managing New AVF. The education was
 conducted through a combination of electronic communications, in person communications and return demonstrations.
 Education is included in the current onboarding process.
- Under the direction of the Renal Nurse Supervisor/ designee monthly infection prevention audits of observed practice in
 accordance with referenced policy will be conducted. Performance feedback will be provided as required. Frequency of
 monitoring will be revaluated by unit leadership based on sustained performance. Performance data will be shared monthly
 at the dialysis unit, and quarterly at unit's QAPI meetings and at the quarterly Organizational Standards of Operation
 Committee chaired by the Chief Medical Officer.
- All Actions will be completed by 12/15/24.

V 147 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 Educate health-care workers regarding the appropriate infection control measures to prevent intravascular catheter-related infections. 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.

III. 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 upon observation and interview, the facility failed to ensure appropriate infection control measures were followed to prevent intravascular catheter (a flexible, long, plastic, y-shaped tube that is threaded through your skin into a central vein in your neck, chest or groin)* -related infections for 1 patient [Pt.#4] of 3 patients sampled. Findings include:

Per observation on 10/21/24 at 12:45 PM, a staff Registered Nurse [RN] was observed during dialysis initiation for Pt.#4. While the RN was accessing Pt.#4's Central Venous Catheter [CVC] on the patient's left upper chest wall in preparation for dialysis treatment, the patient was observed without a mask

Per interview with the facility's Renal Nurse Supervisor [RNS] on 10/21/24 at 3:50 PM, the RNS confirmed that staff should ensure that dialysis patients with Central Venous Catheters [CVCs] are wearing masks during accessing and de-accessing their CVC in order to prevent intravascular catheter-related infections. The RNS confirmed that staff are educated annually on CVC accessing and de-accessing, and the expectation was the patient is to be masked during accessing and de-accessing the CVC. The RNS confirmed the observation was not in accordance with the facility's CVC policy and procedure.

An interview was conducted with the facility's Medical Director on 10/22/2024 at 1:00 PM. The Medical Director stated that 'it doesn't matter' whether accessing a patient's Central Venous Catheter [CVC] during initiation of dialysis or de-accessing the CVC after dialysis is completed, the patient must be wearing a mask for infection control precautions, and staff are to ensure this is done. (https://www.azuravascularcare.com/infodialysis access/types-of-dialysis-access/)

ACTION PLAN

- RENL009: Central Venous Catheter (CVC) Access revised and published 11/4/24 to include ensuring dialysis patients with Central Venous Catheters (CVCs) are wearing masks during accessing and de-accessing.
- Under the direction of the Renal Nurse Supervisor all staff, applicable to their role received education on infection prevention
 practices specifically related to patients wearing masks during accessing and de-accessing their CVC as set forth by
 UVMMC policy RENL009: Central Venous Catheter (CVC) Access. The education was conducted through a combination of
 electronic communications, in person communications and return demonstrations. Education is included in the current
 onboarding process.
- Under the direction of the Renal Nurse Supervisor/ designee monthly infection prevention audits of observed practice in
 accordance with referenced policies will be conducted. Performance feedback will be provided as required. Frequency of
 monitoring will be revaluated by unit leadership based on sustained performance. Performance data will be shared monthly
 at the dialysis unit, and quarterly at unit's QAPI meetings and at the quarterly Organizational Standards of Operation
 Committee chaired by the Chief Medical Officer.
- All Actions will be completed by 12/15/24.

11/13/24 POC approved. Jane Kendall