VERMONT

AGENCY OF HUMAN SERVICES
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
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473504	A. BUILDING _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTRY DIALYSIS UNIT	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	E 000		
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 000	See plan of correction	12/15/24
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	V 113	**Tag V 113 POC accepted on 11/13/24 by J. Kendall/P. Cota**	

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

Carol Mgr 11/12/24

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	Continued From page 1 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 santizing 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	V 113	See plan of correction	12/15/24

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V 113	Continued From page 2 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.	V 113	See plan of correction	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 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.	V 147	**Tag V 147 POC accepted on 11/13/24 by J. Kendall/P. Cota**	

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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]. 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.	V 147	See plan of correction	12/15/24

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V 147	Continued From page 4 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/infodialysisaccess/types-of-dialysis-access/)	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

This Plan of Correction (POC) constitutes written allegation of compliance for the deficiencies cited. However, submission of this POC is not admission that the deficiencies exist or that one was cited correctly, nor is it an admission that the facts listed on the 2567 are accurate. The POC is submitted to meet the requirements established by federal and state law.