

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

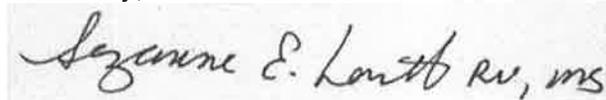
May 5, 2016

North Country Dialysis Unit
189 Prouty Drive
Newport, VT 05855

Enclosed is a copy of your acceptable plans of correction for the survey conducted on March 23, 2016.

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,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 473504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS	V 000		
V 122	<p>An unannounced on site recertification survey was conducted by the Division of Licensing and Protection from 3/21/16 - 3/23/16 to determine compliance with 42 Code of Federal Regulations, Part 405 subpart U, Condition of Participation for coverage of End Stage Renal Disease Services. The following regulatory violations were identified:</p> <p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL</p> <p>[The facility must demonstrate that it follows standard infection control precautions by implementing-</p> <p>(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-]</p> <p>(ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.</p> <p>This STANDARD is not met as evidenced by: Based upon observations, interviews, and record review, the facility failed to follow standard infection control precautions for cleaning and disinfection of contaminated surfaces of a dialysis station, while a patient remained seated next to the station with fistula access needles in place for 1 of 15 patients (Patient #7). Finding includes:</p> <p>Per observation of discontinuation of dialysis treatment for a patient with a AV (arterio-venous) fistula on 3/21/16 at 4:20 PM, Staff Member #2 failed to adhere to infection prevention practices established in the facility policy regarding the cleaning and disinfection of the dialysis patient station. Per review, the policy Infection Prevention Policy: Hemodialysis Out-patient and In-patient</p>	V 122	See attached Plan of Correction	4/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Carol Muzzy p.p. Bonni Martin

TITLE
MSN, RN

(X8) DATE
4/14/16

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 122	Continued From page 1 Care Sites published July 2013 states "I. Infection Prevention Precautions for All Patients B: Cleaning and Disinfection: 1. After each patient treatment, AFTER patient has been discharged from the station, clean environmental surfaces at the dialysis station, including the dialysis bed or chair, countertops, and external surfaces of the dialysis machine.....". At the completion of dialysis, the Staff Member #2 was observed disconnecting the arterial and venous blood line tubing from Patient #7. The AV fistula needles and extension tubing were not removed and Patient #7 remained sitting in the chair at the dialysis station. Staff Member #2 was observed using a bleach cloth and began a partial cleaning of the station in preparation for initiating the chemical disinfection process. Despite the proximity of Patient #7's right arm fistula access and the potential for cross-contamination, Staff Member #2 failed to maintain required infection prevention practice by discharging the patient prior to cleaning and disinfecting the dialysis machine, as per policy. Per interview on 3/21/16 at 4:30 PM, Staff Member #2 confirmed s/he started a partial cleaning of the dialysis station, to initiate the chemical disinfection rinse due to the length of the 1 hour rinse process and due to time constraints of the staff's work schedule, it was important to begin the chemical rinse process as soon as possible.	V 122	See attached Plan of Correction	4/14/16
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE Recommendations for Placement of Intravascular Catheters in Adults and Children I. Health care worker education and training A. Educate health-care workers regarding the ...	V 147	See attached Plan of Correction	4/14/16

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V 147	<p>Continued From page 2</p> <p>appropriate infection control measures to prevent intravascular catheter-related infections.</p> <p>B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.</p> <p>II. Surveillance</p> <p>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.</p> <p>Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.</p> <p>VI. Catheter and catheter-site care</p> <p>B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].</p> <p>This STANDARD is not met as evidenced by: Based upon observations, interviews, and record review, the facility failed to assure all staff consistently adhered to appropriate infection prevention guidelines and practices during the provision of care of central venous catheters for 2 of 15 patients (Patients #2, #13). Findings include:</p> <p>1. Per observation of initiation of dialysis treatment for a patient with a CVC (Central</p>	V 147	See attached Plan of Correction	4/14/16

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V 147 Continued From page 3
Venous Catheter), on 3/21/16 at 12:10 PM, Staff Member #1 failed to adhere to infection prevention practices established in the facility policy regarding accessing of the catheter hubs. Per review the policy, titled Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance, published 9/28/15, stated under; "Procedure: Accessing CVC (for hemodialysis,.....). When accessing central line catheters strict adherence to aseptic technique is critical.....7. Ensure that catheter is clamped. Remove and discard cap, maintaining asepsis. Scrub the port vigorously with new alcohol prep pad for 15 seconds and allow to air dry. Then aseptically attach empty sterile 10cc syringe to uncapped lumen using "no-touch" aseptic technique....13. Repeat with other lumen.." During the process of preparing Patient #2 for connecting to the dialysis machine, Staff Member #1, who was not visualizing a time piece during the procedure, failed to disinfect the hubs of both lumens for a period of 15 seconds. The involved staff member confirmed, during interview immediately following the procedure, that lumen hubs should be scrubbed for a period of 15 seconds each and stated that s/he had used a mental counting technique as a process for calculating the 15 seconds.

2. Staff Member #2 failed to adhere to infection prevention practices established in the facility policy regarding "...strict adherence to aseptic technique...." when drawing blood from a CVC via an arterial injection port as noted in facility policy Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance, published 9/28/15. On the afternoon of 3/21/16 Staff Member #2 was observed accessing Patient #13's injection port bloodline attached to the

V 147 See attached Plan of Correction 4/14/16

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V 147 Continued From page 4
patient's CVC. As directed in policy Lab: Drawing Post Dialysis BUN published 11/12/13, staff are directed before obtaining a blood sample to scrub the injection port of the bloodline prior to using a vacutainer with attached needle-tipped adaptor. Although Staff Member #2 did clean the injection port with a alcohol swab when obtaining the first blood sample, a few minutes later when a second sample was then required to be obtained, Staff Member #2 failed to follow procedure and accessed the injection port without cleansing the injection port with alcohol.

V 147 See attached Plan of Correction

4/14/16

THE
University of Vermont
MEDICAL CENTER

V 000 INITIAL COMMENTS

An unannounced on site recertification survey was conducted by the Division of Licensing and Protection from 3/21/16 - 3/23/16 to determine compliance with 42 Code of Federal Regulations, Part 405 subpart U, Condition of Participation for coverage of End Stage Renal Disease Services. The following regulatory violations were identified:

PLAN OF CORRECTION

V 122 494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL

[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 upon observations, interviews, and record review, the facility failed to follow standard infection control precautions for cleaning and disinfection of contaminated surfaces of a dialysis station, while a patient remained seated next to the station with fistula access needles in place for 1 of 15 patients (Patient #7). Finding includes:

Per observation of discontinuation of dialysis treatment for a patient with a AV (arterio-venous) fistula on 3/21/16 at 4:20 PM, Staff Member #2 failed to adhere to infection prevention practices established in the facility policy regarding the cleaning and disinfection of the dialysis patient station. Per review, the policy Infection Prevention Policy: Hemodialysis Out-patient and In-patient Care Sites published July 2013 states "I. Infection Prevention Precautions for All Patients B: Cleaning and Disinfection: 1. After each patient treatment, AFTER patient has been discharged from the station, clean environmental surfaces at the dialysis station, including the dialysis bed or chair, countertops, and external surfaces of the dialysis machine.....". At the completion of dialysis, the Staff Member #2 was observed disconnecting the arterial and venous blood line tubing from Patient #7. The AV fistula needles and extension tubing were not removed and Patient #7 remained sitting in the chair at the dialysis station. Staff Member #2 was observed using a bleach cloth and began a partial cleaning of the station in preparation for initiating the chemical disinfection process. Despite the proximity of Patient #7's right arm fistula access and the potential for cross-contamination, Staff Member #2 failed to maintain required infection prevention practice by discharging the patient prior to cleaning and disinfecting the dialysis machine, as per policy. Per interview on 3/21/16 at 4:30 PM, Staff Member #2 confirmed s/he started a partial cleaning of the dialysis station, to initiate the chemical disinfection rinse due to the length of the 1 hour rinse process and due to time constraints of the staffs work schedule, it was important to begin the chemical rinse process as soon as possible

Action Plan

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center

*POC met
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TJ*

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(UVMMC) policy Infection Prevention Policy: Hemodialysis Out-patient and In-patient Care Sites with topics reviewed in the policy specific to machine disinfection during the onsite visit completed March 23, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy by April 8, 2016. The Dialysis educator provided policy review, demonstration and observed return demonstration for March 28, 2016. Re-education and acknowledgement as above will be completed by all UVMMC Tech Staff Dialysis units by April 28, 2016.

- Ongoing surveillance of UVMMC infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.

PLAN OF CORRECTION

V 147 494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE

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].

*Pbc amw
4.15.16
TJ/80*

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This STANDARD is not met as evidenced by: Based upon observations, interviews, and record review, the facility failed to assure all staff consistently adhered to appropriate infection prevention guidelines and practices during the provision of care of central venous catheters for 2 of 15 patients (Patients #2, #13). Findings include:

1. Per observation of initiation of dialysis treatment for a patient with a CVC (Central Venous Catheter), on 3/21/16 at 12:10 PM, Staff Member #1 failed to adhere to infection prevention practices established in the facility policy regarding accessing of the catheter hubs. Per review the policy, titled Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance, published 9/28/15, stated under; "Procedure: Accessing CVC (for hemodialysis,....). When accessing central line catheters strict adherence to aseptic technique is critical.....7. Ensure that catheter is clamped. Remove and discard cap, maintaining asepsis. Scrub the port vigorously with new alcohol prep pad for 15 seconds and allow to air dry. Then aseptically attach empty sterile 1Dec syringe to uncapped lumen using "no-touch" aseptic technique13. Repeat with other lumen.."During the process of preparing Patient #2 for connecting to the dialysis machine, Staff Member #1, who was not visualizing a time piece during the procedure, failed to disinfect the hubs of both lumens for a period of 15 seconds. The involved staff member confirmed, during interview immediately following the procedure, that lumen hubs should be scrubbed for a period of 15 seconds each and stated that s/he had used a mental counting technique as a process for calculating the 15 seconds.

2. Staff Member #2 failed to adhere to infection prevention practices established in the facility policy regarding "...strict adherence to aseptic technique" when drawing blood from a vein via an arterial injection port as noted in facility policy Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance, published 9/28/15. On the afternoon of 3/21/16 Staff Member #2 was observed accessing Patient #13's injection port bloodline attached to the patient's CVC. As directed in policy Lab: Drawing Post Dialysis BUN published 11/12/13, staff are directed before obtaining a blood sample to scrub the injection port of the bloodline prior to using a vacutainer with attached needle-tipped adaptor. Although Staff Member #2 did clean the injection port with an alcohol swab when obtaining the first blood sample, a few minutes later when a second sample was then required to be obtained, Staff Member #2 failed to follow procedure and accessed the injection port without cleansing the injection port with alcohol.

Action Plan

1.

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMC) policy Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance reviewed in the policy for appropriate disinfection of port stopper to available staff during the onsite visit completed by March 23, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their

*POC unit
4-15-16
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understanding of the aforesaid policy by April 8, 2016. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate disinfection of hub 15 second cleansing, completed on all available staff by March 23, 2016. Re-education and acknowledgement as above was completed by all UVMMC dialysis units by March 28, 2016. An increase in timing devices were placed on multiple wall surfaces for staff visualization on April 1, 2016 and will be completed at all sites by April 28, 2016.

- Ongoing surveillance of UVMMC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.
- An organizational wide educational communication from the Director of Accreditation and Regulatory Affairs and the Manager of Infection Prevention will reinforce key infection prevention practices that everyone needs to know through an electronic communication in the Steps to Excellence during the month of March 2016.

2.

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMMC) policy Hemodialysis Vascular Access: Central Venous Catheter (CVC) Care and Maintenance and Drawing Post Dialysis BUN to available staff during the onsite visit completed by March 23, 2016. The Dialysis educator provided education to policy for appropriate stopper disinfection at the injection port bloodline completed on all staff by March 28, 2016. Re-education and acknowledgement as above will be completed by all UVMMC dialysis units by April 29, 2016.
- Ongoing surveillance of UVMMC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.

*Poc unit
4-15-16
Jc/ls*