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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	312595	A. BUILDING ______ B. WING ______	C 06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON DIALYSIS CENTER OF MATAWAN	**625 HIGHWAY 34 MATAWAN, NJ 07747**

(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 This was a COVID-19 Focused Infection Control Survey (NJ00136746) conducted on 6/12/20. Madison Dialysis Center of Matawan is not in compliance with 42 CFR, Part 494, Conditions for Coverage (CfC) for End Stage Renal Disease Facilities. Condition and Standard level deficiencies were evident. The following CfC was found to be out of compliance: CfC: 494.30 Infection Control The following Immediate Jeopardy (IJ) findings were identified on 6/24/20: Tag V 142 - Oversight: Monitor and implement biohazard and infection control policies and activities within the dialysis unit. The facility failed to ensure that all visitors, patients, and staff are provided a screening to identify and isolate suspected COVID-19 cases prior to entering the treatment floor. 1. Through direct observation on 6/12/20, the facility failed to ensure that all patients, staff, and visitors are screened to identify COVID-19 prior to entering the treatment floor. a. Upon entrance to the facility on 6/12/20, this surveyor was not screened for flu-like or respiratory symptoms or asked if he/she had contact with COVID-19 positive patients or infectious fluids from a COVID-19 positive patient. b. The COVID-19 Employee and Physician	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 07/09/2020

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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Screening Form dated 6/12/20, contained the name of this surveyor. The form contained the following questions, "To your knowledge, have you been within 6 feet (2 meters) of a COVID-19 positive patient for a priolonged [sic] period of time?*" and "Have you had direct contact with Infectious secreations(e.g. [example] being coughed on by a COVID-19 positive patient) of [sic] a COVID-19 case while not wearing PPE [personal protective equipment] (including facemasks)?" The box indicating "NO" was checked under both questions.

(i) At 1:15 PM, Staff #1 confirmed that this surveyor was not asked the above questions upon entrance to the facility. This surveyor asked why the question boxes were checked "NO", Staff #1 said "I don't know."

c. Upon observation and an interview with Patient [NJ Exec] on [NJ Exec. Order 26], it was identified that Patient [NJ Exec] was not screened for flu-like or respiratory symptoms prior to the being taken to the treatment station. Patient [NJ Exec] stated that he/she had not been asked about any symptoms or having contact with COVID positive patients.

2. A total of eighteen (18) of eighteen (18) COVID-19 screening logs from the months of April, May, and June 2020 were reviewed, it was identified that the facility was not consistently screening patients, staff, and visitors for flu-like or respiratory symptoms.

a. On 4/17/20, one (1) of eleven (11) staff member lacked evidence that a temperature was taken. Nine (9) of eleven (11) staff/visitors and eleven (11) of [NJ Exec. Order 26 4.b.1] patients lacked evidence that they were screened for flu-like or

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V 000	Continued From page 2 respiratory symptoms. b. On 4/20/20, three (3) of eleven (11) staff/visitors and fourteen (14) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. c. On 4/21/20, two (2) of Seven (7) staff and twenty (20) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. d. On 4/22/20, Eight (8) of Nineteen (19) staff/visitors and fourteen (14) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. e. On 5/6/20, eight (8) of twelve (12) staff/visitors and seventeen (17) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. f. On 5/7/20, five (5) of seven (7) staff/visitors and twenty (20) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. g. On 6/5/20, nine (9) of ten (10) staff/visitors and eight (8) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. h. On 6/8/20, three (3) of ten (10) staff/visitors and twenty-one (21) of NJ Exec. Order 26:4 b 1 patients lacked evidence that they were screened for flu-like or respiratory symptoms. i. On 6/12/20, eight (8) of eight (8) staff/visitors and Thirteen (13) of NJ Exec. Order 26:4 b 1 patients lacked	V 000		

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V 000	Continued From page 3	V 000		

evidence that they were screened for flu-like or respiratory symptoms. One (1) of NJ Exec. Order 26.4.b.1) patients lacked evidence that a temperature was taken and two (2) of NJ Exec. Order 26.4.b.1) patients lacked evidence that they were screened for having contact with COVID-19 positive patients.

5. Upon interview on 6/12/20 at 1:10 PM, Staff #1 confirmed the above findings. Staff #1 stated that in the beginning when COVID-19 started they would ask staff, visitors, and patients the questions about all the symptoms and contact with COVID-19 positive persons but as time went on, they got "lax" and don't ask the questions anymore.

This finding resulted in an Immediate Jeopardy (IJ). The Clinic Manager was informed of the IJ and was provided with the IJ Template on 6/24/20 at 10:35 AM.

On 6/24/20, the facility submitted an acceptable Removal Plan for the Immediate Jeopardy findings.

On 6/29/20, an on-site revisit was conducted. During the revisit, visitors and patients were screened appropriately and the screening results were documented on the COVID-19 Screening log. Documentation of staff education on the COVID-19 screening process was reviewed. Staff interviewed revealed an understanding of the facility policy for the COVID-19 screening process for staff, visitors, and patients. It was determined that the components of the removal plan were implemented. As a result of this revisit on 6/29/20, the Immediate Jeopardy for Tag V -0142

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V 000	Continued From page 4 was removed as of 6/29/20.	V 000		
V 110	CFC-INFECTION CONTROL CFR(s): 494.30 This CONDITION is not met as evidenced by: Based on observation, document review, and staff interview, it was determined that the facility failed to implement and maintain effective infection control practices. Findings include: 1. The facility failed to ensure that staff perform hand hygiene in accordance with facility policy. (Cross Refer to Tag V 113, Part A) 2. The facility failed to ensure that soap is available for handwashing. (Cross Refer to Tag V 113, Part B) 3. The facility failed to ensure that staff apply gloves when touching any part of the hemodialysis machine or equipment in the dialysis station. (Cross Refer to Tag V 113, Part C) 4. The facility failed to ensure that contaminated equipment is not placed in a clean area to prevent cross-contamination. (Cross Refer to Tag V 117) 5. The facility failed to ensure that contaminated equipment is clean and disinfected after use. (Cross Refer to Tag V 122, Part A) 6. The facility failed to ensure that equipment is	V 110		

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V 110	Continued From page 5 maintained to allow for cleaning and disinfection. (Cross Refer to Tag V 122, Part B) 7. The facility failed to ensure that upon entrance into the facility, visitors, patients, and staff are screened to identify and isolate suspected COVID-19 cases. (Cross Refer to Tag V 142) 8. The facility failed to ensure that medications are administered aseptically. (Cross Refer to Tag V 143)	V 110		
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: A. Based on observation and facility policy review on 6/12/20, it was determined that the facility failed to ensure that staff perform hand hygiene in accordance with facility policy. Findings include: Reference: Facility policy titled, Personal Protective Equipment, states, "... Hand Hygiene must always be performed after glove removal. ..." 1. At [redacted] AM, while a patient was [redacted] in Station [redacted] Staff #2, picked up the patient's jacket and removed a phone from the pocket and placed it on the chairside table. Staff #2 exited	V 113		

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V 113	Continued From page 6	V 113		

the station, removed and disposed of the his/her gloves, and without performing hand hygiene retrieved a clean pair of gloves from an clean opened glove box.

B. Based on observation and staff interview on 6/12/20, it was determined that the facility failed to ensure that soap is available for handwashing.

Findings include:

1. At [NJ Exec. O] AM in Station [NJ Exe], Staff #2 removed Patient #[NJ Exec. Order 26.4.b.1]s and removed his/her gloves. Staff #2 went to the handwashing sink located inside Station #9 and wetted his/her hands. This handwashing sink lacked a soap dispenser. Staff #2 applied soap from the soap dispenser located above the dirty sink and returned to the clean sink to complete his/her handwashing.

a. Staff #2 confirmed that the clean handwashing sink does not have a soap dispenser and that to get soap you have to go to the dirty sink.

C. Based on observation, staff interview, and review of facility policy on 6/12/20, it was determined that the facility failed to ensure that staff apply gloves when touching any part of the hemodialysis machine or equipment in the dialysis station.

Reference: Facility policy titled, Personal Protective Equipment, states, "... Gloves ... Disposable gloves must be used: ... [bullet] When touching any part of the dialysis machine or equipment at the dialysis station. ..."

1. At [NJ Exec. O] AM, while a [NJ Exec. Order 26]t was [NJ Exec. Order 26.4]g in

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V 113	Continued From page 7 Station [redacted] Staff #3 moved the portable TV arm into position in front of the patient with his/her bare hands. 2. At [redacted] AM, after NJ Exec. Order 26:4.b.1 [redacted], Staff #2 picked up supplies that were on top of the patient's hemodialysis machine with his/her bare hands and placed them on the patient's chairside table.	V 113		
V 117	IC-CLEAN/DIRTY;MED PREP AREA;NO COMMON CARTS CFR(s): 494.30(a)(1)(i) Clean areas should be clearly designated for the preparation, handling and storage of medications and unused supplies and equipment. Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled. Do not handle and store medications or clean supplies in the same or an adjacent area to that where used equipment or blood samples are handled. When multiple dose medication vials are used (including vials containing diluents), prepare individual patient doses in a clean (centralized) area away from dialysis stations and deliver separately to each patient. Do not carry multiple dose medication vials from station to station. Do not use common medication carts to deliver medications to patients. If trays are used to deliver medications to individual patients, they must be cleaned between patients. This STANDARD is not met as evidenced by: Based on two (2) of two (2) observations of stethoscope use, staff interview, and facility policy	V 117		

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V 117	Continued From page 8 review on 6/12/20, it was determined that the facility failed to ensure that contaminated equipment is not placed in a clean area to prevent cross-contamination. Findings include: Reference: Facility policy titled, Dialysis Precautions, states, "... Clean area: An area designated for clean and unused equipment, supplies, ..." 1. At [NJ Exec. Order 26:4.b.1] AM in Station [NJ Exec. Order 26:4.b.1], Staff #3 had a stethoscope around his/her neck during the [NJ Exec. Order 26:4.b.1]n of the patient's [NJ Exec. Order 26:4.b.1]r [NJ Exec. Order 26:4.b.1]). After [NJ Exec. Order 26:4.b.1], Staff #3 exited the station and placed the contaminated stethoscope on the counter at the nursing station then returned to Station [NJ Exec. Order 26:4.b.1]. The bell of the stethoscope was touching the lid of the clean bleach container located on a a cart in front of the counter. 2. At [NJ Exec. Order 26:4.b.1] AM, Staff #2 placed a stethoscope on the patient's lap in Station #[NJ Exec. Order 26:4.b.1] while he/she d[NJ Exec. Order 26:4.b.1]the patient's [NJ Exec. Order 26:4.b.1]. After the procedure, Staff #2 removed the stethoscope from the patient's lap and without cleaning and disinfection, placed it on the counter at a sink, labeled "Clean" across from Station [NJ Exec. Order 26:4.b.1]. Staff #2 then returned to Station [NJ Exec. Order 26:4.b.1]. 3. Upon interview at 11:50 AM, Staff #1 stated that that the bleach cart located in front of the nurses station is considered a clean area and that the contaminated stethoscope should not be placed on the counter at the nurses station until it has been cleaned and disinfected. Staff #1 stated that the clean sink is a clean area and the	V 117		

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V 117	Continued From page 9 contaminated stethoscope should not be placed at the clean sink.	V 117		
V 122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii) [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: A. Based on two (2) of two (2) observations of stethoscope use and a review of facility procedure on 6/12/20, it was determined that the facility failed to ensure that staff clean and disinfect the stethoscope after each use. Findings include: Reference: Facility procedure titled, Cleaning and Disinfection of the Stethoscope, states, "... 1. The stethoscope should be wiped with a [sic] either 70% isopropyl alcohol wipe or cloth dampened with 1:100 hypochlorite solution after each use. ..." 1. At NJ Exec. Or AM in Station NJ Ex, Staff #3 had a stethoscope around his/her neck during the d NJ Exec. Order 26:4.b.1 of the patient's NJ Exec. Order 26:4.b.1 - NJ Exec. Order 26:4.b.1). After NJ Exec. Order 26:4.b.1, Staff #3 exited the station and without cleaning and disinfection, placed the stethoscope on the	V 122		

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V 122	Continued From page 10 counter at the nursing station then returned to Station [redacted]. a. Staff #3 did not clean and disinfect the stethoscope prior to leaving it on the counter. The contaminated stethoscope was available for use on another patient. 2. At [NJ Exec. Order] AM, Staff #2 placed a stethoscope on the patient's lap in Station # [redacted] while he/she [NJ Exec. Order 26.4.b1]d the patient's [NJ Exec. Order 26.4.b1]. After the procedure, Staff #2 removed the stethoscope from the patient's lap and without cleaning and disinfection and placed it on the counter at the clean sink located next to the medication preparation area then returned to Station [redacted]. a. Staff #2 did not clean and disinfect the stethoscope prior to leaving it on the counter at the clean sink. The contaminated stethoscope was available for use on another patient. 3. Upon interview at 11:50 AM, Staff #1 stated that staff should clean and disinfect the stethoscope after use and prior to returning it to a clean area. B. Based on observation and review of facility policy, it was determined that the facility failed to ensure that the blood pressure cuffs in four (4) of nine (9) stations (Station #6, #7, #8, and #9) could be cleaned and disinfected after use. Findings include: Facility policy titled, Cleaning and Disinfection of the Dialysis Station, states, "... After use, all non-disposable equipment and supplies must be disinfected with 1:100 bleach ... 1. During a tour of the treatment floor on 6/12/20,	V 122		

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V 122	Continued From page 11 the Velcro portions of the blood pressure cuffs at Station #6, Station #7, Station #8, and Station #9, contained a large amount of lint, thus preventing the surface of the cuff from being a cleanable surface.	V 122		
V 142	IC-O-SIGHT-MONITOR ACTIVITY/IMPLEMENT P&P CFR(s): 494.30(b)(1) The facility must- (1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit; This STANDARD is not met as evidenced by: Based on observation, staff and patient interview, and a review of facility documents on 6/12/20, it was determined that the facility failed to ensure that all visitors, patients, and staff are provided a screening to identify and isolate suspected COVID-19 cases prior to entering the treatment floor on eighteen (18) of eighteen (18) COVID-19 screening logs reviewed. Findings include: Reference: Facility policy titled, Coronavirus Disease Screening and Infection Control Practices in Fresenius Kidney Care (FKC) Dialysis Clinics, states, " ... Patient, Visitor, Staff, Physician, and Physician Extender Screening All patients, visitors, staff, physicians, and physician extenders entering a FKC dialysis clinic must be screened for ongoing signs and symptoms of COVID-19 prior to admittance to the dialysis treatment floor or while waiting in the dialysis treatment waiting area. ... Screening	V 142		

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V 142	Continued From page 12 requirements: ... [bullet] ... Inquire whether patients, visitors, staff, or physician/physician extenders have these symptoms or combination of symptoms: [bullet] Cough; [bullet] Shortness of breath; or [bullet] Difficulty breathing. [bullet] Fever (>_ [greater or equal to] 100.0 degrees Fahrenheit) [bullet] Chills [bullet] Repeated shaking with Chills [bullet] Muscle pain [bullet] headache [bullet] Sore throat [bullet] New loss of taste or smell [bullet] Congestion or runny nose [bullet] Nausea or vomiting [bullet] Diarrhea [bullet] All patients, visitors, staff, or physician/physician extenders should be asked the following questions: [bullet] To their knowledge, have they been within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; ... [bullet] Have they had direct contact with infectious secretions of a COVID-19 case ... while not wearing PPE [personal protective equipment] ... Documentation of Screening of Staff, physician, physician extender, patient and visitor response(s) to the pre-shift screening questions should be recorded in the ... screening document(s) ..." 1. Upon entering the facility at 9:10 AM, this surveyor was met by Staff #8 in the patient waiting room. Staff #1, a registered nurse, came into the waiting room and stated, "I just need to take your temperature." and communicated the result to Staff #8. Staff #8 recorded the result on a log. This surveyor asked Staff #1 is there anything else you need? Staff #1 stated "No. Just your temperature." Staff #1 then escorted this surveyor into a conference room off the treatment floor. a. Staff #1 did not ask this surveyor any questions related to signs and symptoms of	V 142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	312595	A. BUILDING ______ B. WING ______	C 06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON DIALYSIS CENTER OF MATAWAN	625 HIGHWAY 34 MATAWAN, NJ 07747

(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 142	Continued From page 13 illness or contact with COVID-19 positive persons. This is not in accordance with facility policy. 2. Upon interview at 9:15 AM, Staff #1 stated that everyone's temperature must be taken prior to entering the facility. Staff #1 stated that if you have a fever you cannot come into the facility. Staff #1 stated that the information is documented on the COVID-19 Employee and Physician Screening Form which is used for staff, physicians and visitors. a. Staff #1 stated that the facility has NJ Exec. Order NJ Exec. Order 26:4 b 1 patients dialyzing on the third shift on Tuesday, Thursday, and Saturday. Staff #1 stated that this shift is only for NJ Exec. Order 26:4 b 1 patients and that no other patients are in the facility when the patients are brought from the nursing home for dialysis. 3. Upon interview at NJ Exec. O AM, Patient #2 was observed entering the facility. Staff #1 took Patient NJ Ex's temperature and asked Patient NJ Ex "Are you having any problems?" Patient NJ Ex answered "low blood pressure yesterday." a. Staff #1 did not ask Patient NJ Ex if he/she had any of the symptoms of COVID-19 or any other questions related to COVID-19 screening. This is not in accordance with facility policy. 4. Upon interview at 9:46 AM, Patient NJ Ex stated that the staff does not ask any specific questions about whether he/she has been in contact with a COVID-19 positive person or if he/she is experiencing any symptoms of COVID-19 when he/she arrives. Patient NJ Ex stated "They only ask me, 'Are you having any problems?' If I have any	V 142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 142	Continued From page 14	V 142		

problems, I am supposed to tell them. Like today, I told them about my NJ Exec NJ Exec. Order 26:4 b 1 e yesterday." This surveyor asked Patient NJ Ex if he/she was asked by staff if he/she was having respiratory or flu-like symptoms or if he/she has had contact with a COVID-19 positive patient before being brought to the treatment station. Patient #NJ stated "No. I think if I was I have to tell them though."

5. Upon interview at 11:10 AM, Staff #3 stated that upon arrival the registered nurse will take the patient's temperature prior to coming to the treatment floor. Staff #3 stated that when he/she comes to work his/her temperature is taken and it's written in the logbook. Staff #3 stated that he/she is not asked any other questions. Staff #3 stated "If I am sick, I am supposed to tell the nurse, no one asks me."

6. Upon interview at 11:30 AM, Staff #2 stated that when a patient arrives the registered nurse takes the patient's temperature before they come to the station. Staff #2 stated that upon entering the building only his/her temperature is taken to see if he/she has a fever.

7. A total of eighteen (18) of eighteen (18) COVID-19 screening logs from the months of April, May, and June 2020 were reviewed, it was identified that the facility was not consistently screening patients, staff, and visitors for flu-like or respiratory symptoms.

a. On 4/17/20, one (1) of eleven (11) staff member lacked evidence that a temperature was taken. Nine (9) of eleven (11) staff/visitors and eleven (11) of NJ Exec. Order 26 4.b.1 patients lacked evidence that they were screened for flu-like or

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V 142	Continued From page 15 respiratory symptoms. b. On [NJ Exec. Order 26], three (3) of eleven (11) staff/visitors and fourteen (14) of [NJ Exec. Order 26:4 b 1] patients lacked evidence that they were screened for flu-like or respiratory symptoms. c. On [NJ Exec. Order 26], two (2) of Seven (7) staff and twenty (20) of [NJ Exec. Order 26:4 b 1] patients lacked evidence that they were screened for flu-like or respiratory symptoms. d. On [NJ Exec. Order 26], Eight (8) of Nineteen (19) staff/visitors and [NJ Exec. Order 26:4 b 1] of [NJ Exec. Order 26:4 b 1] patients lacked evidence that they were screened for flu-like or respiratory symptoms. e. On [NJ Exec. Order], eight (8) of twelve (12) staff/visitors and seventeen (17) of [NJ Exec. Order 26:4 b 1] patients lacked evidence that they were screened for flu-like or respiratory symptoms. f. On [NJ Exec. Order], five (5) of seven (7) staff/visitors and twenty (20) of [NJ Exec. Order 26:4 b 1] patients lacked evidence that they were screened for flu-like or respiratory symptoms. g. On 6/5/20, nine (9) of ten (10) staff/visitors and eight (8) of [NJ Exec. Order 26:4.b.1]) patients lacked evidence that they were screened for flu-like or respiratory symptoms. h. On 6/8/20, three (3) of ten (10) staff/visitors and twenty-one (21) of [NJ Exec. Order 26:4 b 1]) patients lacked evidence that they were screened for flu-like or respiratory symptoms. i. On 6/12/20, eight (8) of eight (8) staff/visitors and Thirteen (13) of [NJ Exec. Order 26:4 b 1] patients lacked	V 142		

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V 142	Continued From page 16	V 142		

evidence that they were screened for flu-like or respiratory symptoms. One (1) of [NJ Exec. Order 26.4.b.1] patients lacked evidence that a temperature was taken and two (2) of [NJ Exec. Order 26.4.b.1]) patients lacked evidence that they were screened for having contact with COVID-19 positive patients.

8. Upon interview on 6/12/20 at 1:10 PM, Staff #1 confirmed the above findings. Staff #1 stated that in the beginning when COVID-19 started they would ask staff, visitors, and patients the questions about all the symptoms and contact with COVID-19 positive persons but as time went on, they got "lax" and don't ask the questions anymore.

9. The COVID-19 Employee and Physician Screening Form dated 6/12/20, contained the name of this surveyor. The form contained the following questions, "To your knowledge, have you been within 6 feet (2 meters) of a COVID-19 positive patient for a priolonged [sic] period of time?*" and "Have you had direct contact with Infectious secreations(e.g. [example] being coughed on by a COVID-19 positive patient) of [sic] a COVID-19 case while not wearing PPE [personal protective equipment] (including facemasks)?" The box indicating "NO" was checked under both questions.

a. At 1:15 PM, Staff #1 confirmed that this surveyor was not asked the above questions upon entrance to the facility. This surveyor asked why the question boxes were checked "NO", Staff #1 said "I don't know."

10. Upon interview at 1:10 PM, Staff #1 confirmed that this surveyor was not screened for symptoms of COVID-19 or asked questions about

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V 142	Continued From page 17 contact with COVID-19 positive persons upon arrival or before going onto the treatment floor. 11. A review of a Staff Meeting Attendance sheet dated 4/8/20, contained documentation that Policy and Procedure updates and COVID-19 education which included education on the facility policy titled, Coronavirus Disease Screening and Infection Control Practices in Fresenius Kidney Care (FKC) Dialysis Clinics was provided to staff. a. There is evidence that Staff #1, Staff #2, Staff #3, and Staff #8 received education of the COVID-19 screening process on 4/8/20.	V 142		
V 143	IC-ASEPTIC TECHNIQUES FOR IV MEDS CFR(s): 494.30(b)(2) [The facility must-] (2) Ensure that clinical staff demonstrate compliance with current aseptic techniques when dispensing and administering intravenous medications from vials and ampules; and This STANDARD is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined that the facility failed to ensure that medications are administered aseptically. Findings include: Reference: Facility Policy titled, Medication Preparation and Administration Policy, states, " ... Infection Control ... [bullet] Aseptic technique will be used to prepare and administer IV [intravenous] medications. ..."	V 143		

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V 143	Continued From page 18 1. On 6/12/20 at 10:00 AM, Staff #2 cannulated the patient in Station #[redacted]. Staff #2 knocked a syringe of heparin that was on the patient's chairside table onto the floor. Staff #2 picked up the syringe and placed it back on the patient's chairside table. a. Staff #7, in the presence of Staff #2, then prepared to administer the heparin into the fistula needle tubing. Staff #2 did not inform Staff #7 that the syringe of Heparin had fallen on the floor. b. This surveyor asked Staff #2, in the presence of Staff #7, if the syringe had fallen on the floor. Staff #2 hesitated. Staff #7 asked Staff #2 if the syringe had fallen on the floor and Staff #2 stated "Yes but its ok the cap is still on it." Staff #7 did not administer the medication, discarded the syringe, and prepared the medication again. c. Staff #7 stated that Staff #2 should have told him/her that the syringe fell on the floor.	V 143		
V 637	QAPI-INDICATOR-INF CONT-TREND/PLAN/ACT CFR(s): 494.110(a)(2)(ix) The program must include, but not be limited to, the following: (ix) Infection control; with respect to this component the facility must- (A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence; (B) Develop recommendations and action plans to minimize infection transmission, promote immunization; and (C) Take actions to reduce future incidents.	V 637		

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V 637	Continued From page 19 This STANDARD is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility failed to ensure that it collects, maintains, and aggregates data, for its infection control review. Findings include: Reference: Facility policy titled, Coronavirus Disease Screening and Infection Control Practices in Fresenius Kidney Care (FKC) Dialysis Clinics, states, " ... Documentation of Screening of Staff, physician, physician extender, patient and visitor response(s) to the pre-shift screening questions should be recorded in the ... screening document(s) ... The patient, visitor, staff, and physician screening documents should be reviewed in QAI [Quality Assurance Improvement] with IDT [Interdisciplinary Team] and Medical Director. ..." 1. Upon request on 6/18/20 at 12:35 PM, Staff #9 was unable to provide evidence that the March, April, and May COVID-19 screening logs for staff, physicians, physician extenders, patients and visitors responses were discussed in QAI, with the IDT or the medical director. a. During a telephone interview on 6/18/20 at 12:40 PM, Staff #9 confirmed the above findings. Staff #9 stated no one at the facility is monitoring or reviewing the COVID-19 screening logs.	V 637		

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Control
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POC accepted nrt 7/10/20

V110 (V110-148) 494.30 Infection Control

The Governing Body of this facility acknowledges its responsibility to ensure all staff follow approved policies and procedures for infection control, identify concerns in infection control technique and continue to develop, analyze and revise action plans regarding infection control concerns to ensure ongoing compliance.

The Governing Body on 7/7/2020, reviewed the Statement of Deficiencies and developed the following Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution.

The Governing Body began meeting weekly on 6/29/2020 to review the results of the progress on the Plan of Correction ensuring that deficiencies are addressed, both immediately and with long term resolution. The Governing Body will determine when the frequency of these meetings may be reduced to the regular quarterly schedule. Effective immediately:

- The Director of Operations (DO) will analyze and trend all data and monitor/audit results as related to this Plan of Correction prior to presenting the monthly data to the QAI Committee.
- A specific plan of action encompassing the citations as cited in the Statement of Deficiency has been added to the facility's monthly QAI (Quality Assessment and Performance Improvement) agenda.
- The QAI Committee is responsible to review and evaluate the Plan of Correction to ensure it is effective and is providing resolution of the issues.
- The DO will present a report on the Plan of Correction data and all actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues.
- The Governing Body, at its meeting of, designated the DO to serve as Plan of Correction Monitor and provide additional oversight. They will participate in QAPI and Governing Body meetings. This additional oversight is to ensure the ongoing correction of deficiencies cited in the Statement of Deficiency through to resolution as well as ensure the Governance of the Facility is presented current and complete data to enhance their governance oversight role.

Minutes of the Governing Body and QAI meetings, as well as monitoring forms and educational documentation will provide evidence of these actions, the Governing Body's direction and oversight and the QAI Committees ongoing monitoring of facility activities. These are available for review at the facility.

The responses provided for V113, V117, V122, V142 and V143 describe, in detail, the processes and monitoring steps taken to ensure that all deficiencies as cited within this Condition are corrected to ensure ongoing compliance. Refer to specific V-Tags.

Completion Date: 7/2/20

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Accepted 7/10/20 nr

V113 IC-Wear gloves/hand hygiene

Beginning 6/24/2020, the Education Coordinator (EC) or designee held staff meetings, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policies & Procedures:

FMS-CS-IC-II-155-090A - Hand Hygiene

FMS-CS-IC-II-155-090C - Hand Hygiene Procedure

FMS-CS-IC-II-155-080A - Personal Protective

Equipment

FMS-CS-IC-II-155-070A - Dialysis Precautions

Emphasis was placed on:

- Performing hand hygiene before and after direct contact with patients.
- Performing hand hygiene between donning and doffing of gloves, prior to obtaining clean supplies.
- Ensure direct patient care (DPC) staff will immediately perform hand hygiene after leaving patient
- treatment station. On 7/7/2020, Biomedical technician (BMT) installed soap dispenser by the handwashing sink.
- Ensure DPC staff are wearing gloves when touching any part of the dialysis machine, equipment or supplies within the patient dialysis station.
- Ensure DPC staff are wearing appropriate personal protective equipment (PPE) when in contact with inanimate objects near the patient.

The in-services were completed by 7/2/2020 with documentation of the training on file at the facility.

For ongoing compliance, Beginning 7/8/2020, the Director of Operations (DO), or Charge Nurse (CN) or designee conducted daily audits on all shifts to ensure staff are utilizing gloves and performing hand hygiene as per policy and procedure until 100% compliance is observed. A POC specific auditing tool will be used for the audits. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 4 weeks then resume regularly scheduled audits based on QAI calendar. Monitoring will be done through the Clinic audit checklist.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible for overall

compliance. Completion Date: 7/2/20

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accepted POC ret 7/10/20

V117 IC-Clean/dirty;med prep area;no common med carts

Beginning 6/24/2020, the Education Coordinator (EC) or designee held staff meetings, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policies & Procedures:

FMS-CS-IC-II-155-070A - Dialysis Precautions

FMS-CS-IC-II-155-110A - Cleaning and Disinfection of the

Dialysis Station FMS-CS-IC-II-155-123A - Cleaning and

Disinfection of the Stethoscope Policy

FMS-CS-IC-II-155-123C - Cleaning and Disinfection of the

Stethoscope Procedure Emphasis was placed on:

- Ensuring direct patient care staff (DPC) are aware of the facility's designated clean and dirty areas.
- Clean supplies/equipment will be separated from dirty/contaminated areas.
- Ensuring all reusable instruments and equipment taken into the dialysis station, including the stethoscope is thoroughly cleaned and disinfected in between use and prior to being stored and taken to a common clean area.

The in-services were completed by 7/2/2020 with documentation of the training on file at the facility.

For ongoing compliance, Beginning 7/8/2020, the Director of Operations (DO), or Charge Nurse (CN) or designee conducted daily audits on all shifts to ensure staff are cleaning and disinfecting the stethoscope after each use and prior to storing in a clean area until 100% compliance is observed. A POC specific auditing tool will be used for the audits. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 4 weeks then resume regularly scheduled audits based on QAI calendar. Monitoring will be done through the Clinic audit checklist.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible for overall

compliance. Completion Date: 7/2/20

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accepted POC 7/10/20 NS

V122 IC-Disinfect surfaces/equip/written protocols

For immediate compliance, on 6/25/2020, any identified BP cuffs with excess lint were replaced.

Beginning 6/24/2020, the Education Coordinator (EC) or designee held staff meetings, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policies & Procedures:

FMS-CS-IC-II-155-070A - Dialysis Precautions

FMS-CS-IC-II-155-123A - Cleaning and Disinfection of the

Stethoscope Policy FMS-CS-IC-II-155-123C - Cleaning and

Disinfection of the Stethoscope Procedure FMS-CS-IC-II-155-110A -

Cleaning and Disinfection of the Dialysis Station

FMS-CS-IC-II-155-122A - Cleaning and Disinfection of the Blood Pressure

Cuff Policy FMS-CS-IC-II-155-122C - Cleaning and Disinfection of the

Blood Pressure Cuff Procedure Emphasis was placed on:

- Ensuring all reusable instruments and equipment taken into the dialysis station, including the stethoscope is thoroughly cleaned and disinfected in between use and prior to being stored and taken to a common clean area.
- Blood pressure cuffs with excess lint will be replaced as needed to ensure appropriate cleaning of the surface of the velcro portion.
- Ensuring all equipment, including blood pressure cuffs are maintained to allow for effective cleaning
- and disinfection. Ensuring all contaminated surfaces, equipment and supplies are cleaned and disinfected as per policy and procedure.

The in-services were completed by 7/2/2020 with documentation of the training on file at the facility.

For ongoing compliance, Beginning 7/8/2020, the Director of Operations (DO), or Charge Nurse (CN) or designee conducted daily audits on all shifts to ensure staff are cleaning and disinfecting the stethoscope prior to storing in a clean area and ensure blood pressure cuffs are free of excess lint until 100% compliance is observed. A POC specific auditing tool will be used for the audits. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 4 weeks then resume regularly scheduled audits based on QAI calendar. Monitoring will be done through the Clinic audit checklist.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI

of Correction and all other actions taken toward the
resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective
and is providing resolution of the issues.

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible for overall

compliance. Completion Date: 7/2/20

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accepted 7/10/20 [illegible]

V142 IC-O-sight: monitor activities & implement P&P

Beginning 6/24/2020, the Clinical Manager (CM), or Education Coordinator (EC) or designee held staff meetings, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policies & Procedures:

FMS-CS-IC-II-155-221A Coronavirus Disease Screening and Infection Control Practices in Fresenius Kidney Care (FKC) Dialysis Clinics.

COVID-19 Employee and Physician Screening Form

COVID-19 Patient and Visitor Screening Form

Emphasis was placed on:

- Ensuring suspected COVID positive staff, patients and visitors are immediately identified and isolated.
- Ensuring all patients, visitors, staff, physicians, and physician extenders entering the dialysis clinic must be screened for ongoing signs and symptoms of COVID-19 prior to admittance to the dialysis treatment floor.
- Screening requirements includes daily monitoring of patients, visitor, staff, physician and physician extender temperature.
- Screening requirements includes if the individual is presents or is experiencing flu-like symptoms or any combination of the following symptoms: cough, shortness of breath, difficulty breathing, fever >/=100.0 degrees Fahrenheit, chills, repeated shaking with shills, muscle pain, headache, sore throat, new loss of taste or smell, congestion or runny nose, nausea or vomiting, diarrhea.
- Facility will utilize screening documents to record temperature and screening of symptoms and close
- contact exposure. In the event the patients, visitor, staff, physician and physician extender experiences flu like symptoms or a combination of any of the following symptoms, the facility will take precaution and adhere to policies and procedure to protect them and others from the respiratory illness.

Any staff member not present for the in service on 6/24/2020 received education upon their return to work and documentation of the training is on file at the facility.

For immediate compliance, a daily tracking tool was developed and utilized to ensure patients, visitors, staff, physicians, and physician extenders entering the dialysis clinic are screened and documentation is complete. The POC specific auditing tool will be used for the audits by the Clinical Manager or Charge Nurse (or delegated personnel) for 2 weeks. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 4 weeks then resume regularly scheduled audits based on QAI calendar. Monitoring will be done through the QAI for 3 months to ensure 100% compliance and then monthly for 6 months.

Issues of non-compliance will include re-education and counseling.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly.

Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible for overall

compliance. Completion Date: 7/2/20

MADISON DIALYSIS CENTER OF MATAWAN
Plan of Correction
for Infection
Control
Provider Identification Number:
31-2595 Date of Survey: 6/12/20

accepted 7/10/20 [illegible]

V143 IC-Aseptic techniques for IV meds

For immediate compliance, on 6/12/2020, the contaminated medication syringes was discarded.

Beginning 6/26/2020, the Education Coordinator (EC) or designee held staff meetings, elicited input, and reinforced the expectations and responsibilities of the facility staff on the following Policies & Procedures:

FMS-CS-IC-II-155-070A - Dialysis Precautions

FMS-CS-IC-II-120-040A - Medication Preparation and

Administration Policy FMS-CS-IC-I-120-040C - Medication

Preparation and Administration Procedure Emphasis was placed on:

- Ensuring Registered Nurse (RN) staff are performing aseptic technique upon preparation and administration of medications.
- Clean or sterile supplies are protected from contamination.
- Supplies/items that cannot be disinfected will be discarded if contaminated.

The in-services were completed by 7/2/2020 with documentation of the training on file at the facility.

For ongoing compliance, Beginning 7/8/2020, the DO or designee will conduct daily audits on all shifts to ensure RN staff are ensuring medications are administered aseptically until 100% compliance is observed. A POC specific auditing tool will be used for the audits. Once compliance is sustained, the Governing Body will decrease frequency to weekly for 4 weeks then resume regularly scheduled audits based on QAI calendar. Monitoring will be done through the Clinic audit checklist.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the is responsible for overall compliance.

Completion Date: 7/2/20

MADISON DIALYSIS CENTER OF MATAWAN
Plan of Correction
for Infection
Control
Provider Identification Number:
31-2595 Date of Survey: 6/12/20

accepted 7/10/20 ns

V637 QAPI-Indicator-Inf cont-trend/plan/act

On 6/26/2020, the Director of Operations (DO), reviewed the following policies and procedure during QAI with Interdisciplinary team (IDT) and Medical Director.

FMS-CS-IC-II-155-221A Coronavirus Disease Screening and Infection Control Practices in Fresenius Kidney Care (FKC) Dialysis Clinics.

FMS-CS-IC-I-101-001A - Quality Assessment and Performance Improvement Program

(QAPI) Emphasis was placed on:

- Ensure compiled data related to COVID-19 screening logs for patients, visitors, staff, physician and physician extenders are reviewed in QAI with Interdisciplinary team (IDT) and Medical Director.
- Ensure screening logs is analyzed to identify trends and establish baseline information on incidence
- of non-compliance. IDT Team will ensure findings are trended to determine patterns of breaches for any issue identified and develop performance improvement plans for any practice breaches.

Education and audit records will be on file in the facility.

For ongoing compliance, Beginning 6/26/2020, the DO or designee, will monitor the QAPI program for three months or until 100% compliance is observed with reporting, analyzing, tracking and trending data, and development of performance improvement plans. DO or designee will report results to the Governing Body (GB), and the GB will be responsible for further guidance and sustained compliance.

The Medical Director will review the results of audits each month at the QAI Committee meeting monthly. The Director of Operations is responsible to review, analyze and trend all data and Monitor/Audit results as related to this Plan of Correction prior to presenting to the QAI Committee monthly. The Director of Operations is responsible to present the status of the Plan of Correction and all other actions taken toward the resolution of the deficiencies at each Governing Body meeting through to the sustained resolution of all identified issues. The QAI Committee is responsible to provide oversight, review findings, and take actions as appropriate. The Governing Body is responsible to provide oversight to ensure the Plan of Correction, as written to address the issues identified by the Statement of Deficiency, is effective and is providing resolution of the issues.

Documentation of education, monitoring, QAI, and Governing Body is available for review.

The Director of Operations is responsible for overall

compliance. Completion Date: 7/2/20