

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
--	--

(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 0000 Bldg. 00	<p>This was a Federal ESRD complaint investigation survey.</p> <p>Complaint #: IN00181259</p> <p>Survey Date: 10/6/2015</p> <p>Facility #: 5157</p> <p>Medicaid Vendor #:100172360D</p> <p>Provider ID: 152512</p> <p>The complaint is substantiated, related deficiencies are cited</p>	V 0000		
V 0122 Bldg. 00	<p>494.30(a)(4)(ii) IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL [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>Based on record review, interview, and</p>	V 0122	V122 Facility administrator held and mandatory in-service for all	11/08/2015

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
--	--

(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
	<p>observation, the facility failed to ensure dialysis stations had been appropriately cleaned and disinfected after use in 1 (#s 1) of 2 cleaning and disinfection of the dialysis station observations.</p> <p>Findings Include:</p> <p>1. On 10/6/15 at 1045, employee A, a patient care technician was observed to clean dialysis station #23 to prepare for use by the next patient. The PCT failed to clean the television screen and blood pressure cuff attached to the treatment station.</p> <p>3. The observation was discussed with the facility administrator, on 10-6-15 at 4:20 PM. The administrator agreed that they televisions and blood pressure cuffs should be cleaned between each patient use of the treatment station.</p> <p>3. The facility's September 2014 "Infection Control for Dialysis Facilities" policy number 1-05-01 states, "Teammates will thoroughly wipe down all non-disposable items and equipment such as the blood pressure cuff, the inside and outside of the prime container, clamps, and the dialysis delivery systems, with an appropriate disinfectant after every treatment."</p>		<p>clinic teammates on 10/9/2015,10/10/2015, and 10/21/2015. In-service included but was not limited to: review of Policy and Procedure 1-05-01: Infection Control for Dialysis Facilities,Policy and Procedure 1-05-01A: Use of Alcohol Based Hand Rubs. Teammates (TMs) must ensure proper procedurefor disinfection with bleach solution between patient treatments of machine,chair and surrounding equipment. Teammates must wipe down all non-disposable items and equipment including blood pressure cuffs and the television aftereach treatment. Verification ofattendance at in-service will be evidenced by teammate's signature on in-servicesheet. Charge Nurseor Clinical Coordinator will conduct infection control audits for every shiftdaily x 2 weeks, then weekly x 2 weeks, then monthly. Facility Administrator (FA)/Charge nurse willreview results of all audits with teammates during home room meetings and withMedical Director during monthly Facility Health Meetings (FHM), minutes willreflect. FacilityAdministrator is responsible for compliance with this plan of correction Completiondate: 11/8/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
--	--

(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 0401 Bldg. 00	<p>494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the treatment floor and patient treatment areas had been kept clean and orderly in 1 of 1 days observed.</p> <p>The Findings Include:</p> <p>1. Upon arrival to the facility, on 10-6-15, a tour was completed of the treatment floor area at 10:25 AM. The following was observed:</p> <p>A. A large amount of yellowish-white crystalline substance was observed on the floor and under the cabinet area in treatment station #1, coating the dialysis machine hoses. The floor in this area was visibly very soiled.</p> <p>B. The wall boxes and hose connectors at treatment stations 1, 2, 10, 11, 20, 21, 22,23, 24 and 25 appeared very soiled and contained a moderate amount of brownish-yellow crystalline substance both in the box and</p>	V 0401	<p>V401 All facilityfloors, wall boxes and hose connectors immediately cleaned; leak at station 1repaired; cart removed from area. Biomed Technician contacted and workingwith Pest Control Services toaddress gnats and Pest Control Servicesactively treating facility; janitorial service scheduled to clean floorsnightly; facility floors scheduled to be stripped and waxed quarterly permaintenance agreement. FA held amandatory in-service on 10/9/2015, 10/10/2015, and 10/21/2015 for all TMs. In-service included but was not limitedto: review of Policy & Procedure #8-04-01: Physical Environment. TMs educated that facility must provide andmonitor a sanitary environment. 1) Facility must remain clean, uncluttered, andorganized; 2) TMs must immediately clean up spills; facility floors must remainclean free from dirt/debris; 3) All wall boxes and hoses must be cleaned at aminimum end of each treatment day, when visibly soiled, or when area residue isobserved; 4) All TMs are</p>	11/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152512	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP CODE 3834 S EMERSON AVE BLDG B INDIANAPOLIS, IN 46203
--	--

(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
	<p>surrounding the hose fittings.</p> <p>C. Insects, appearing to be fruit flies, were observed in the water room and in the patient reception area.</p> <p>D. The floor near the water room was very soiled and a wheeled cart containing numerous empty containers labeled, disinfectant, acid, and bicarbonate was parked near the water room door. The cart was visibly soiled and covered with a yellowish crystalline substance and dust.</p> <p>2. The administrator acknowledged that the floors were soiled in some areas of the clinic and that the cart with empty containers "needed to be moved" during exit conference on 10-6-15 at 420 PM.</p> <p>3. The facility's December 2012 "Physical Environment" policy number 8-04-01 states, "The dialysis facility will be designed, constructed, equipped, and maintained to provide dialysis patients, teammates, and the public a safe, functional, and comfortable treatment environment."</p>		<p>responsible to ensure cleanliness and good repair of facility and must notify FA of areas needing repair/attention. Verification of attendance at in-service will be evidenced by teammate's signature on in-service sheet. Charge nurse will do a nightly audit for cleanliness of the wall boxes and hoses daily 2 weeks then weekly going forward. Charge Nurse or Clinical Coordinator will conduct infection control audits for every shift daily x 2 weeks, then weekly x 2 weeks, then monthly. FA/Charge nurse will review results of all audits with teammates during home room meetings and with Medical Director during monthly FHM, minutes will reflect. Facility Administrator is responsible for compliance with this plan of correction. Completion date: 11/8/2015</p>	