

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 12/21/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 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 visit was for a Federal Post Condition resurvey of an ESRD provider.</p> <p>Survey dates: 12-21-2021</p> <p>ICHD census: 64, there is no isolation room. Isolation waiver was presented on 11-17-2021.</p> <p>Total: 64</p> <p>During this post condition resurvey, Marion County Dialysis was found to have been in compliance with the Condition for Coverage 494.30: Infection Control. Three (3) standard citations were corrected. One (1) standard citation was recited.</p> <p>1/6/2022 Quality Review by Area 3</p>	V 0000		
V 0113 Bldg. 00	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE 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.</p> <p>Based on record review, observation, and interview, the facility failed to ensure the proper use of Personal Protective Equipment (PPE) while on the treatment floor during 1 of 1 post condition revisit observation day. (Employee: AA and Patient #: 2, 4, 5, and 6)</p> <p>Findings include:</p>	V 0113	<p>Facility Administrator (FA) will hold mandatory in-service for all clinical Teammates (TMs). In-service will include but will not be limited to: review of Policy & Procedure # 1-05-01: Infection Control for Dialysis Facilities emphasizing 1) TMs must wear disposable gloves appropriately</p>	01/21/2022

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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 12/21/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARION COUNTY DIALYSIS	STREET ADDRESS, CITY, STATE, ZIP COD 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>1. A DaVita Incorporated policy dated September 2007 and revised on October 2021, was provided by the Facility Administrator (FA), employee DD on 12-21-2021 at 12:38 PM. The policy titled, "Infection Control for Dialysis Facilities" indicated but was not limited to "... Hand hygiene is to be performed upon entering the patient treatment area, prior to gloving, after removal of gloves...gloves should be worn when going from a "dirty" area or task to a "clean" area or task... after touching one patient or their dialysis delivery system and before arriving to care for another patient... or another dialysis delivery system...".</p> <p>2. During an observation on 12-21-2021 at 9:30 AM, the Patient Care Technician (PCT), Employee AA, was observed touching the dialysis machine at station #8 with a gloved hand. Employee AA removed their glove and placed it on top of the computer terminal table. There was no hand hygiene completed. Employee AA reapplied the same glove, typed on the dialysis computer with one hand. Employee AA then removed their glove. No hand hygiene was completed.</p> <p>3. During an observation on 12-21-2021 at 9:40 AM, Patient #2 was observed holding their dialysis access site in their left upper extremity (LUE) post treatment with a gloved right hand. Once stable the patient removed their glove and left the treatment floor. The patient was not offered the opportunity for hand hygiene.</p> <p>4. During an observation on 12-21-2021 at 9:45 AM, Employee AA was observed exiting the back door to the treatment floor wearing their gloves. Employee re-entered the treatment floor wearing gloves and caring a jug of bicarbonate.</p>		<p>when caring for the patient or touching the patient's equipment at the dialysis station. 2) TMs must remove gloves and perform hand hygiene between dirty and clean tasks with same patient, between each patient and station. 3) TMs must remove gloves and perform hand hygiene before entering clean supply area. 4) TMs must perform hand hygiene every time gloves removed. 5) TMs must instruct and encourage patients every treatment to perform hand hygiene upon entering the treatment floor; and perform hand hygiene prior to leaving the unit after glove removal and prior to touching any clean supply or area to assist in avoiding the risk of cross contamination. Verification of attendance at in-service will be evidenced by TMs signature on in-service sheet.</p> <p>FA or designee will conduct infection control audits daily x 2 weeks, weekly x 2 weeks, and then monthly. FA will review results of all audits with TMs during home room meetings and with Medical Director during monthly Facility Health Meeting (FHM), minutes will reflect.</p> <p>FA is responsible for compliance with this plan of correction</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 12/21/2021
--	---	--	---

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>5. During an observation on 12-21-2021 10:40 AM, Patient # 4 was observed holding their dialysis access site in their right upper extremity (RUE) post treatment with a gloved right hand. Once stable the patient removed their glove and left the treatment floor. The patient was not offered the opportunity for hand hygiene.</p> <p>6. During an observation on 12-21-2021 at 9:40 AM, Patient #5 was observed holding their dialysis access site in their left upper extremity (LUE) post treatment with a gloved right hand. Once stable the patient removed their glove and left the treatment floor. The patient was not offered the opportunity for hand hygiene.</p> <p>7. During an observation on 12-21-2021 at 11:25 AM, Employee AA was observed removing their gloves while at station #9. Employee AA placed their gloves on top of the computer station. No hand hygiene was performed.</p> <p>8. During an observation on 12-21-2021 at 11:40 AM, Employee AA was observed wearing one glove on their right hand. Employee AA touched the dialysis machine and removed their hold glove and held it in their hand. Employee AA placed the glove on the top of the computer table at station #5. Employee AA applied a glove to their right hand and typed on the computer. They then reached behind the dialysis machine to grab the prime container with an ungloved left hand. They emptied the prime container keeping their glove on their right hand and returned to typing. No hand hygiene was performed.</p> <p>9. During an observation on 12-21-2021 at 11:46 AM, Patient #6 was observed holding their dialysis access site in their left upper extremity</p>			

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

PRINTED: 01/07/2022
FORM APPROVED
OMB NO. 0938-039

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 12/21/2021
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 DEFICIENCY (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>(LUE) post treatment with a gloved right hand. Once stable the patient left the treatment floor still holding their access site with a gloved hand. The patient was not offered the opportunity for hand hygiene.</p> <p>10. On 12-21-2021 at 12:10 PM, Employee DD when queried about the hand hygiene practices indicated that while completing their weekly audits there has not been full compliance with proper hand hygiene. Employee DD indicated that weekly audits should continue for a period of time.</p>				