STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152547	A. BUILDING ______ B. WING ______	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIALYSIS CLINIC INC	**1719 W 10TH ST INDIANAPOLIS, IN 46222**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with the 42 CFR 494.62 Survey Dates: 12-11-2023, 12-12 and 12-13-2023 Facility #: 010129 CCN#: 152547 Stations: 27 includes 1 isolation room. Census by Service Type: In-Center Hemodialysis: 98 Home Peritoneal Dialysis: 10 No Home Hemodialysis Program Total Census: 108 At this Emergency Preparedness survey, Dialysis Clinic Incorporated was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. QR by Area 3 on 12-18-2023.	E 000		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 494.62(b)(1) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must	E 018		12/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/2024

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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E 018	Continued From page 1	E 018		

develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]

[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):]
Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of

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E 018	Continued From page 2	E 018		

assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure a current list of all patient prescriptions and contact information was available for 1 of 1 Emergency Preparedness Program.

Findings Include:

A policy titled "Emergency Disaster Plan"

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E 018	Continued From page 3 indicated but was not limited to, " ... Policies and Procedures ... Patient, Staff and Visitor Tracking System ... B. Patients, staff and visitors will be tracked by a typed current census list or by using the patient registry ..." During a review of the agency's Evacuation binder at A-Bay and B-Bay, the binder evidenced patient prescription reports dated 09-15-2023. The agency failed to ensure the list was up-to-date with new and current patient dialysis prescription reports and contact information. During an interview with the Nurse Manager and Area Operations Director on 12-11-2023 at 4:05 PM, they indicated the evacuation binders were on the floor at each bay and were to be taken with them in an emergency. They indicated they had admitted new patients since 09-15-2023.	E 018		
V 000	INITIAL COMMENTS This visit was for a Federal Recertification and Complaint Survey of an ESRD provider. Surveyor Dates: 12-11-2023, 12-12 and 12-13-2023 Complaint: Anonymous, IN00423106 with unrelated Federal deficiencies cited. Facility #: 010129 CCN#: 152547 Stations: 27 includes 1 isolation room. Census by Service Type: In-Center Hemodialysis: 98	V 000		

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V 000	Continued From page 4 Home Peritoneal Dialysis: 10 No Home Hemodialysis Program Total Census: 108 QR by Area 3 on 12-18-2023.	V 000		
V 113	IC-WEAR GLOVES/HAND HYGIENE CFR(s): 494.30(a)(1) Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure the staff used Personal Protective Equipment (PPE) and hand hygiene appropriately while on the treatment floor by 8 of 8 Patient Care Technicians. (Patients: #12, 13, 21, 24, 33, and 34) (Employees: Patient Care Technician (PCT) 4 (three times), 8, 10, and 11) Findings Include: 1. Review of a dated 10-2014, Dialysis Clinic Incorporated policy titled, "Hand Hygiene" indicated but was not limited to, " ... To ensure proper hand hygiene to reduce the risk of spreading infections ... indications for hand hygiene include contact with a patient's intact skin, before and after an aseptic task, after body fluid exposure risk ...before and after glove removal ... " 2. On 12-11-2023 at 8:20 AM, a sign posted on	V 113		12/29/23

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V 113		V 113		

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the wall above the sink at the entrance to the treatment area was reviewed. The sign titled, "How to Handrub? Rub Hands for Hand Hygiene! Wash Hands When Visibly Soiled!" provided pictures and written instructions on how to complete hand washing and how to complete a hand rub with hand sanitizer which indicated the best practice to prevent infection.

3. On 12-13-2023 at 2:28 PM, facility documents dated 08-30-2023 through 08-31-2023, titled "ESRD Core Survey Task 3b Observations of Hemodialysis Care and Infection Control Practices" were provided by the Clinical Manager, Admin 2. The documents indicated a review of infection control audits completed by the Education Director, Admin 5.

4. During an observation on 12-11-2023 at 2:11 PM, PCT 4, discontinued the treatment for Patient #33, at Station B-4. Patient #33 held pressure on their right upper vascular access site with a left gloved hand. Patient #33 discarded their glove in the trash receptacle beside their chair. PCT 4 ass
8. On 12/11/23 at 2:15 PM, Patient #21 was observed holding pressure to the left upper arm fistula site with a gloved hand after access was discontinued. After securing a dressing to the access site, PCT 11 assisted the patiet to remove and discard the glove and escorted the patient to the scale and the exit. PCT 11 failed to ensure the patient completed hand hygiene after holding pressure to the deaccessed site.

9. On 12/11/23 at 2:33 PM, Patient #24 was observed holding pressure to the right upper arm fistula site with a gloved hand after access was discontinued. After securing a dressing to the access site, PCT 8 assisted the patient to remove

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V 113	Continued From page 6 and discard the glove and escorted the patient to the scale and the exit. PCT 8 failed to ensure Patient #24 completed hand hygiene after holding pressure to the deaccessed site.	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 observation, record review, and interview, the facility failed to ensure the proper storage of supplies and biohazard materials in 1 of 1 stand alone in-center dialysis facilities and 1 of 1 home peritoneal dialysis facilities. Findings Include:	V 117		12/14/23

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V 117	Continued From page 7 1. Review of an undated Dialysis Clinic Incorporated policy titled, "Maintenance of Equipment" indicated but was not limited to, " ... All equipment used in the dialysis facility will be maintained free of defects which could be a potential hazard to patients and personnel .... " 2. During a flash tour on 12-11-2023 at 8:45 AM, observed in the cabinet a sharps container, container of soap, Hoyer lift strap, and a black soap dispenser under the sink of the treatment area. During an interview on 12-12-2023 at 3:35 PM, the Clinical Manager, Admin 2, confirmed nothing is to be in the cabinets under the sinks. Admin 2 indicated they had removed the hand soap dispenser, sharps container, soap container, and Hoyer lift strap from the cabinet under the sink in the treatment area. 3. On 12/12/23 at 9:10 AM, a review of the home dialysis area evidenced 2 watering cans and a stack of unwrapped paper hand towels under the sink in the common medication area.	V 117		
V 402	PE-BUILDING-CONSTRUCT/MAINTAIN FOR SAFETY CFR(s): 494.60(a) The building in which dialysis services are furnished must be constructed and maintained to ensure the safety of the patients, the staff and the public. This STANDARD is not met as evidenced by: Based on observation, record review, and	V 402		12/14/23

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V 402	Continued From page 8	V 402		

interview the facility failed to ensure the in-center equipment were constructed and maintained to ensure the safety of all patients, staff, and visitors and were equipped with an eye wash station or another system for flushing a blood splash or caustic chemicals in 1 of 1 stand alone in-center dialysis facilities.

Findings Include:

1. Review of an undated Dialysis Clinic Incorporated policy titled, "Maintenance of Equipment" indicated but was not limited to, " ... All equipment used in the dialysis facility will be maintained free of defects which could be a potential hazard to patients and personnel .... "

2. During a flash tour observation on 12-11-2023 at 8:20 AM, noted the hot and cold water handles of the patient's sink were broken at the entrance of the treatment area.

During an interview on 12-12-2023 at 3:35 PM, the Area Director of Operations, Admin 1, confirmed the handles of the patient sink were broken.

3. During a flash tour on 12-11-2023 at 9:20 AM, observed the water room area was without an eyewash station nor supplies for flushing the eyes in the event of a biohazard splash or exposure to caustic chemicals.

During an interview on 12-11-2023 at 9:20 AM, the Biomed Technician, confirmed there was not an eyewash station in the treatment area. The Biomed Technician further indicated the eyewash station and shower had been removed during reconstruction.

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V 402	Continued From page 9 4. During an interview on 12-11-2023 at 4:30 PM, Admin 1, and the Clinical Manager, Admin 2, confirmed there should be a station with eyewash water bottles in the water treatment area for flushing of the eyes, exposed to biohazard materials or caustic chemicals.	V 402		
V 407	PE-HD PTS IN VIEW DURING TREATMENTS CFR(s): 494.60(c)(4) Patients must be in view of staff during hemodialysis treatment to ensure patient safety, (video surveillance will not meet this requirement). This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a patient's access site remained uncovered during dialysis treatments for 1 of 1 stand alone in-center dialysis facilities. (Patients: #8, 11, 12, 18, 20, 21, 24, 26, 27, 31, 33, 36, 37, 38, 39, 40, 41, 42, 43, 45, and 46) Findings Include: 1. Review of a dated 11-2023, agency policy titled, "Vascular Access Monitoring and Surveillance," indicated but was not limited to, " ... Monitoring -the examination and evaluation of the vascular access by means of physical examination to detect physical signs that suggest the presence of dysfunction ... " 2. During a flash tour on 12-11-2023 at 8:25 AM, Patient #11 was observed at Station #A-3. Patient #11 right upper arteriovenous fistula (an abnormal connection between an artery and vein	V 407		12/15/23

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that provides access for dialysis treatment) was covered with a black jacket.

3. During an observation on 12-11-2023 at 10:45 AM to 11:50 AM, observed Patient #33, at Station #B-4. Patient #33 was fully covered with a blue blanket.

4. During an observation on 12-11-2023 at 10:45 AM to 11:50 AM, observed Patient #12, at Station #B-2. Patient #12 was fully covered with a blue blanket. The patient's access was not fully visible to the staff.

5. During an observation on 12-11-2023 at 1:35 PM to 2:16 PM, observed Patient #36, at Station #B-1. Patient #36's access was covered with a maroon coat. The patient's access was not fully visible to the staff.

6. During an observation on 12-11-2023 at 1:35 PM to 2:16 PM, observed Patient #37, at Station #B-8. Patient #37 was fully covered with a pink circle-designed blanket. The patient's access was not fully visible to the staff.

Durin
7. On 12-12-2023 at 12:40 PM, an observation of A-Bay evidenced Patients #26 at A2, #38 at A3, #39 at A8, and #40 at A9 had their accesses covered. At 12:55 PM, an observation of B-Bay evidenced Patients #27 at B12, #31 at B6, #41 at B8, and #42 at B13 had their accesses covered. The agency failed to ensure the patient's access sites were visible at all times.
8. On 12-11-23 at 8:30 AM, Patient #43 was observed receiving dialysis at station A8. The patient's head was fully covered with a knit hat which was pulled down so it covered the patient's

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eyes and the bridge of their nose. A blanket covered the patient from their feet to their upper lip, including their left arm and left upper arm fistula site. The patient and their access site failed to be visible while receiving dialysis.

On 12-11-23 at 8:30 AM, Patient #20 was observed receiving dialysis at station A6. The patient's arms and body were fully covered with a blanket and the access site was not visible.

9. On 12-11-23 at 8:35 AM, PCT 6 indicated patient access sites did not need to remain uncovered as long as they were frequently checked by staff throughout the treatment.

10. On 12/11/23 at 11:05 PM, a focused observation of access sites was conducted in bay A. The following patients evidenced access sites which were completely covered:
1. Patient #18, Station A3
2. Patient #24, Station A4
3. Patient #46, Station A6
4. Patient #21, Station A8
5. Patient #45, Station A10
6. Patient #8, Station A13

On 12/11/23 at 4:05 PM, the Administrator indicated all access sites should be fully visible at all times.