STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	152607	A. BUILDING 00 B. WING	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
US RENAL CARE NORTH MUNCIE DIALYSIS	800 S TILLOTSON STE 1 MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a Federal complaint survey of an ESRD Provider. Survey Dates: December 6, 9, and 10, 2024 Complaint: IN00446727 with unrelated deficiencies cited. Complaint: IN00446469 with unrelated deficiencies cited. Census by Service Type: In-Center Hemodialysis: 112 Home Hemodialysis: 2 Home Peritoneal dialysis: 19 Total Active Census: 133 Isolation Room: 1 Abbreviations: RN Registered Nurse PCT Patient Care Technician ICHD In-center Hemodialysis MSW Masters Social Worker IDG Interdisciplinary Group QR 12/16/24 A2	V 0000	A Governing Body (GB) was held on 12/18/2024 to review the statement of deficiencies and plan of correction.	
V 0113 Bldg. 00	494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE Based on observation, record review, and interview, the dialysis facility failed to ensure hand hygiene was performed according to facility policy for 3 of 6 PCTs observed (PCT 1, 4, and 6). Findings include:	V 0113	The Facility Administrator (FA) or designee will in-service all direct care staff on policies C-IC-0060 (Hand Hygiene) and C-IC-0010 (Infection Control and Precautions for Patients). Education will	01/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Pharis	RN,BSN,CNN	12/23/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	1. Review of the Hand Hygiene policy, revised 08/2020, indicated " ...Hand Hygiene will be performed ... Prior to entering and on exiting station to provide care to patient ... Before clean/aseptic procedure ... After touching patient surroundings ... After gloves are removed..." 2. Review of the Personal Protective Equipment (PPE) policy, revised 07/2023, indicated " ... Hand hygiene is performed before donning and after doffing PPE...." 3. An ICHD treatment floor observation was conducted on 12/09/2024 from 3:15 PM to 5:30 PM. At 4:21 PM, observed PCT 4 doff gloves and donn new gloves without first performing hand hygiene. At 4:27 PM, observed the PCT doff gloves and started pushing biohazard waste bin to another location. A machine alarmed in Station 16, and PCT 4 donned gloves without first performing hand hygiene and then touched the machine. During an interview on 12/09/2024 at 4:48 pm, PCT 4 indicated hand hygiene should be performed after everything, before everything, and between everything. PCT 4 further indicated hand hygiene should be performed after glove removal. 4. An ICHD treatment floor observation was conducted on 12/09/2024 from 3:15 PM to 5:30 PM. At 4:42 PM and 5:10 PM, observed PCT 1 doff gloves and entered supply drawer without first performing hand hygiene. At 4:57 PM, observed PCT 1 doff gloves and immediately donn new gloves without first performing hand hygiene. During an interview on 12/09/2024 at 5:28 PM,		emphasize glove changes and hand hygiene when transitioning between clean and dirty tasks, moving between patient stations, and performing hand hygiene after glove removal. Staff members unable to attend the in-service will be educated on their first day back at work. Staff Infection Control Audits will be conducted on 25% of patients daily for two weeks, then weekly for four weeks, monthly for three months, and quarterly thereafter per the Quality Management Workbook audit schedule. The FA will review all education and audit results in monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made, additional education provided as needed, and monitoring will continue until adherence is achieved.	

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	PCT 1 relayed HH should be performed anytime you change your gloves, in between patients, and when touching machines. 5. An ICHD treatment floor observation was conducted on 12/10/2024 from 11:20 AM to 12:45 PM. At 12:27 PM, observed PCT 6 doff gloves and donn new gloves without first performing hand hygiene. At 12:31 PM, observed PCT 6 doff gloves and performed hand hygiene. PCT 6 then typed on the computer with bare hands. PCT then donned gloves without first performing hand hygiene. During an interview on 12/10/2024 at 12:42 PM, PCT 6 relayed hand hygiene should be performed when entering or exiting the treatment floor, before touching the machine, between patients, before cannulation, after glove removal, and immediately before donning new gloves.			
V 0550 Bldg. 00	494.90(a)(5) POC-VASCULAR ACCESS-MONITOR/REFERRALS Based on observation, record review, and interview, the dialysis facility failed to ensure staff disinfected the fistula or graft access site for at least 30 seconds with an alcohol wipe for 2 of 2 PCTs observed accessing a fistula or graft (PCT 6 and 7). Findings include: 1. Review of the Assessment and Cannulation for AV [arteriovenous] Fistula/Graft and Patient Self Cannulation policy, revised 10/2023, indicated " ...Access preparation ... Disinfect each access site separately with one of the below options ... Alcohol Prep Pad ... Utilize a rubbing motion for at	V 0550	The Facility Administrator (FA) or designee will in-service all direct care staff on policy CTI-0030: Assessment and Cannulation for AV Fistula/Graft and Patient Self-Cannulation, focusing on fistula/graft site disinfection. Education will emphasize rubbing with an alcohol prep pad for at least 30 seconds. Staff members unable to attend the in-service will be educated on their first day back at work. The FA or designee will conduct patient care staff checkoffs and	01/09/2025

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	least 30 seconds seconds ..." 2. On 12/10/2024 at 11:35 AM, PCT 7 was observed accessing Patient #15's AV fistula or graft. PCT 7 wiped the patient's skin at the access site for 10 seconds with an alcohol swab prior to cannulation. During an interview on 12/10/2024 at 12:35 PM, PCT 7 relayed the cannulation site should be wiped for 30 seconds when using alcohol wipes. 3. On 12/10/2024 at 12:20 PM, observed PCT 6 accessed Patient #16's AV graft. PCT 6 wiped the patient's skin at the access site for 10 seconds with an alcohol swab prior to the first cannulation and again for 10 seconds prior to the second cannulation. During an interview on 12/10/2024 at 12:42 PM, PCT 6 relayed she didn't recall there being a certain time for wiping the site with alcohol. She indicated she wipes with alcohol from seconds to a minute.		perform Vascular Access Treatment Initiation audits on 25% of patients daily for two weeks, weekly for four weeks, and monthly for three months, resuming quarterly audits per the Quality Management Workbook audit schedule. The FA will review all education and audit results in monthly QAPI and Governing Body (GB) meetings to track and trend adherence. If adherence does not improve, the Plan of Correction (POC) will be re-evaluated, revisions made, additional education provided as needed, and monitoring will continue until adherence is achieved.	