STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152539	A. BUILDING _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAD COUNTIES DIALYSIS	528 N GRANDSTAFF DR AUBURN, IN 46706

(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 visit was for a Federal Recertification Core Survey of an ESRD Provider. Survey Dates: June 14 and 15, 2022 Total census: 34 Incenter hemodialysis: 34 Isolation room: Waiver QA: Area 2 June 28, 2022	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 record review, interview, and observation, the facility failed to ensure staff provided care in accordance with the facility's infection control and hand hygiene policies and procedures in 3 of 3 observation periods conducted, creating the potential to negatively affect the facility's 34 current in-center patients. Findings include: 1. Review of an agency policy titled "Policy: 1-05-01 Infection Control for Dialysis Facilities" dated 10/2021, indicated " ... gloves should be changed when ... going from a "dirty" area or task to a "clean" area or task ...."	V 113	V113 The Facility Administrator or designee will conduct mandatory in-service(s) for all clinical teammates On Policy 1-05-01 "Infection Control for Dialysis Facilities" and 1-05-01A "Use of Alcohol-Based Hand Rubs". Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Gloves should be changed when: …going from a "dirty" area or task to a "clean" area or task…2) Alcohol-based hand rubs: Rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry. 3) Hand hygiene is to be performed …prior to gloving, after removal of gloves, after contamination with blood or other infectious material, after patient and dialysis delivery system contact, between patients even if the contact is casual, before touching clean areas such as supplies…The Facility Administrator or designee will conduct observational infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. Continued on page 2	7/14/22

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

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V 113	Continued From page 1 2. Review of an agency document titled "Monthly Infection Control Audit" dated 01/2020, indicated " ... gloves are changed ... after handling waste containers ... alcohol based hand sanitizer applied to all surfaces of hands ... rub until dry ... process takes about 20 seconds ...." 3. Review of an agency policy titled "Use of Alcohol-Based Hand Rubs" dated 10/2019, indicated " ... rub hands together covering all surfaces of hands and fingers until hand rub has evaporated and hands are dry ...." 4. During observation period #2 on 6/15/22 from 9:30 AM to 11:30 AM: A. Observed at 9:30 AM, PCT #1 (patient care technician) in dialysis station #8, after obtaining alcohol - based hand sanitizer into hands, PCT #1 rubbed their hands together for 6 seconds, then donned a pair of gloves, and then removed a needle and applied a clean gauze pad to Patient #3. B. Observed at 9:40 AM, PCT #3 with gloved hands, to pull a mobile sharps container to dialysis station #1, then without completing hand hygiene, PCT #3 removed a needle from Patient #9. PCT #3 then removed their gloves and donned a clean pair of gloves, without completing hand hygiene. C. Observed at 10:40 AM, in dialysis station #6, PCT #1 was observed to don clean gloves, without hand hygiene, and then touched the central venous catheter of Patient #11. 5. During observation period #3 on 6/15/22 from 1:30 PM to 2:30 PM, observed PCT #1 at 2:25	V 113	V113 Continued from page 1 The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance Performance Improvement meetings, known as Facility Health Meetings, with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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V 113	Continued From page 2 PM with gloved hands, to touch the inner lid of a mobile sharps container and then pulled to dialysis station #1, then, without completing hand hygiene, provided care to Patient #13, when they clamped the blood line and attached a syringe. 6. During an interview on 6/15/22 at 2:55 PM, Administrator #2 indicated hand hygiene and a glove change should be done after touching a dirty area such as a sharps disposal cart and before touching a clean area or prior to any patient contact. Administrator #2 indicated that after application of the facility's alcohol-based hand sanitizer, hands should be rubbed together until dry and was required before donning gloves and before providing patient care or patient contact. 7. During observation period #1 on 6/14/22 at 10:00 AM, PCT #1 was observed to breach infection control and hand hygiene policy during the discontinuation of use of one patient's central venous catheter (CVC; tubing inserted into a large vein above the heart). PCT #1 completed a hand rub with the facility provided alcohol based gel for 12 seconds, then approached and touched the dialysis computer, then donned a pair of gloves and, without completing hand hygiene, unclamped the tubing on the dialysis machine and then attached saline flush syringes to the Patient's central venous catheter ports. PCT #1 then used one gloved hand and pushed the foot of the Patient's dialysis chair towards the floor, and then returned to the Patient's CVC, without hand hygiene, and flushed the lines and administered heparin (blood thinner) into the CVC ports.	V 113		
V 115	IC-GOWNS, SHIELDS/MASKS-NO STAFF	V 115	V115 The Facility Administrator or designee will Continued on page 4	7/14/22

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V 115	Continued From page 3 EAT/DRINK CFR(s): 494.30(a)(1)(i) Staff members should wear gowns, face shields, eye wear, or masks to protect themselves and prevent soiling of clothing when performing procedures during which spurting or spattering of blood might occur (e.g., during initiation and termination of dialysis, cleaning of dialyzers, and centrifugation of blood). Staff members should not eat, drink, or smoke in the dialysis treatment area or in the laboratory. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure employees wore their personal protective equipment (face mask) appropriately, while providing care in the treatment area, during 1 of 3 observation periods. Findings include: On 6/14/22 at 9:30 AM, observed patient care technician #1 providing direct patient care in the treatment area, with their face mask below their nose. Based on an agency document titled "Monthly Infection Control Audit" dated 01/2020, indicated " ... mask worn over nose and mouth ...." During an interview on 6/15/22 at 2:55 PM, Administrator #2 indicated employees were to cover their nose when wearing a face mask.	V 115	V115 Continued from page 3 conduct mandatory in-service(s) for all clinical teammates on Policy 1-05-01 "Infection Control for Dialysis Facilities" and Davita "Monthly Infection Control Audit" beginning 6/24/22. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Appropriate PPE will be worn whenever there is the potential for contact with body fluids, hazardous chemicals, contaminated equipment and environmental surfaces, for example, patient care areas. 2) …mask worn over nose and mouth…The Facility Administrator or designee will conduct observational infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	
V 116	IC-IF TO STATION=DISP/DEDICATE OR DISINFECT CFR(s): 494.30(a)(1)(i)	V 116	V116 The Facility Administrator or designee will conduct mandatory in-service(s) for all clinical teammates On Policy 1-05-01 "Infection Control Continued on page 5	7/14/22

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V 116	Continued From page 4 Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient. -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff disinfected medical equipment between patient use in 1 of 3 observation periods, creating the potential to affect all 34 current in-center patients. Findings include: During observation period #2 on 6/15/22 from 9:30 AM to 11:30 AM, observed PCT #3 (patient care technician) at 9:40 AM to pick up an infrared thermometer from a counter in the treatment area, and take into a dialysis station, and took a forehead temperature of Patient #9. PCT #3 then placed the thermometer back on the the counter in treatment center without decontamination of the thermometer after its use. Review of an agency policy titled "Policy 1-05-01 Infection Control for Dialysis Facilities" dated 10/2021, indicated " ... non-disposable items are	V 116	Continued from page 4 for Dialysis Facilities" beginning 6/24/22. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Non-disposable items are to be disinfected between patients. 2) If electronic thermometers… are used, measures will be taken to prevent cross contamination between patients. 3) For example, the thermometer should not be placed on potentially contaminated equipment such as the dialysis delivery system. 4) If the potential for contamination exists, the device outercasing is wiped with an appropriate disinfectant before being returned to clean area or using on another patient. The Facility Administrator or designee will conduct observational infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with the Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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V 116	Continued From page 5 to be disinfected between patients ... electronic thermometers ... measures will be taken to prevent cross contamination between patients ...the device outer casing is wiped with an appropriate disinfectant before returned to clean area or using on another patient ...." During an interview on 6/15/22 at 2:55 PM, Administrator #2 indicated staff are to disinfect the thermometer after each use.	V 116		
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: Based on observation and interview, the facility failed to ensure their staff stored the daily 1:100 bleach solution, used for decontamination of the dialysis stations and equipment, in a manner that prevented loss of the disinfectant properties in 3 of 3 treatment floor observation periods conducted, creating the potential to affect the facility's 34 current in-center patients. Findings include: During observation period #1 on 6/14/22 from 9:30 AM to 10:20 AM, at 9:30 AM observed that	V 122	V122 The Facility Administrator or designee will conduct mandatory in-service(s) for all clinical teammates On Policy 1-05-08 "Bleach Policy" beginning 6/24/22. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) Bleach solution needs to be covered with a secure lid and the solution should not be placed in the splash zone. NOTE: Without a secure lid, the bleach solution is open to air causing the solution to degrade over time and become less effective. The Facility Administrator or designee will conduct infection control audits daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal infection control audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	7/14/22

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V 122	Continued From page 6 the bleach solution located on a counter across from Station #6 in the treatment area, was left open to the air for more than 5 minutes, when staff failed to close the lid after wetting their cleaning cloths with the solution. During observation period #2 on 6/15/22 from 9:30 AM to 11:30 AM, it was observed at 10:35 AM and at 11:25 AM, that the bleach solution located on a counter across from Station #6 in the treatment area, was left open to the air for more than 5 minutes, when the staff failed to place the lid on the container, after wetting their cleaning cloths with the solution. During observation period #3 on 6/15/22 from 1:30 PM to 2:30 PM, at 2:15 PM observed an open container of bleach solution on the counter across from Station #6 in the treatment area. There was no lid covering the solution for more than 5 minutes. During an interview on 6/15/22 at 2:55 PM, Administrator #2 indicated the lid to the bleach solution would be off while staff wet their cleaning cloths with the solution or when clamps are placed in or taken out of the solution, otherwise, the lid was to be replaced after each use to maintain the disinfectant properties.	V 122		
V 715	MD RESP-ENSURE ALL ADHERE TO P&P CFR(s): 494.150(c)(2)(i) The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending	V 715	V715 A Governing Body meeting with the Medical Director, Facility Administrator, Director of Nursing and Regional Operations Director was held and reviewed the results of the survey ending on 6/24/2022. The Governing Body reviewed Policy COMP-DD-017 "Medical Director Qualifications and Responsibilities" with the Medical Director to include the following: 1) Continued on page 8	7/14/22

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V 715	Continued From page 7 physicians and nonphysician providers; This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow their policy and ensure expired medical supplies were removed and unavailable for patient use, for 1 of 1 agency. Findings include: 1. During a facility flash tour on 6/14/22 at 9:30 AM, observed the following expired supplies: A. A Yankaur suction set (used to suction secretions in the mouth) on top of the crash cart with an expiration date of 7/01/2021. B. In the top drawer of the crash cart was a ClearGuard HD (antimicrobial cap placed on catheters) with an expiration date of 12/26/2021 and povidine-iodine prep pads (antiseptic cleanser to prevent skin infection) with an expiration date of 4/2020. 2. During a tour of the supply room on 6/14/22 at 2:45 PM, observed an open box of BD Safety-Lok syringes (injection device designed to protect healthcare workers from needle stick injuries) with an expiration date of 4/30/2022. 3. Review of policy titled, "Policy: 1-05-01 Infection Control for Dialysis Facilities" dated 10/2021, indicated " ... the contents of packages will not be used beyond the expiration date on the package ...." 4. During an interview on 6/15/22 at 2:55 PM,	V 715	V715 Continued from page 7 Medical Director responsibilities include, but arenot limited to, the following: 1) Oversight of policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility. The Facility Administrator or designee will conduct mandatory in-service(s) for all clinical teammates On Policy 1-05-01 “Infection Control for Dialysis Facilities” and Policy 1-02-08 “Emergency Equipment Checks” beginning 6/24/22. Verification of attendance is evidenced by a signature sheet. Teammates will be instructed using surveyor observations as examples with emphasis on, but not limited to the following: 1) The contents of packages will not be used beyond the expiration date on the package. 2) The following equipment checks will be performed by a licensed nurse teammate to verify the designated equipment is available and functional: Weekly: … Emergency cart (crash cart) is clean, operational and supplies/medications have not expired. The expired supplies on the crash cart were replaced with supplies with a current date. The expired box of syringes were replace with a box of syringes with a current date. The Facility Administrator or designee will conduct audits on the supplies in the emergency kit and the store room daily for two (2) weeks then weekly for two (2) weeks to verify compliance with facility policy. Ongoing compliance will be verified monthly during internal audits. Instances of non-compliance will be addressed immediately. The Facility Administrator or designee will review the results of the audits with teammates during homeroom meetings and with Medical Director during monthly Quality Assurance and Performance Improvement meetings known as Facility Health Meetings with supporting documentation included in the meeting minutes. The Facility Administrator is responsible for compliance with this plan of correction.	

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V 715	Continued From page 8 Administrator #2 indicated expired supplies would not be as effective for patient use and were to be removed from stock.	V 715		